SOMETHING'S NOT RIGHT: EXPLORING THE LIVED EXPERIENCE OF HEALTH ANXIETY

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ABSTRACT

Changes in the diagnostic criteria for health anxiety calls for a closer investigation of the experiences of those who excessively worry about their health. This study uses a social constructionist perspective to qualitatively investigate the lived experience of people who identify as excessively worrying about their health. Experiences of nine participants were explored in semi-structured interviews. Through a thematic analysis, six key themes were identified: 'relationships', 'invalidation', 'insight', 'better safe than sorry', 'vulnerability' and 'therapy.' Overall, participants experience their health anxiety as debilitating, with challenges that included interactions with health professionals, a sense of responsibility for health and a feeling of vulnerability in relation to their bodies. However, previous research suggesting a lack of insight in health anxiety was called into question and the benefits of interacting with psychological therapies shared. Participants reflected a sense of invalidation within the medical sphere and a need for recognition, support and engagement with professionals that does not serve to further stigmatise this group.

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TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

LIST OF APPENDICES

CHAPTER 1: INTRODUCTION

It is not uncommon for us to worry about our health. This worry is often adaptive, after all, good health is intrinsic to our survival (Abramowitz & Braddock, 2008). Being mindful of our health might convince us to pay a visit to our doctor, or our dentist, or to get outside for a walk. However, for some people, health concerns can become overwhelming and an enduring source of distress (Abramowitz & Braddock, 2008). The majority of research around this phenomenon is largely pathologising, with most of the literature exploring this experience through a diagnostic lens. Literature in this field can also prove confusing, with the terms health anxiety and hypochondriasis often being used interchangeably. These inconsistencies in terminology reflect the changing understanding of this experience and the recent reframing of the experience of 'hypochondriasis' as 'health anxiety.' The framing of health anxiety through this biomedical model has caused an absence of understanding of how this phenomenon is experienced by the people who suffer and those around them. As such, further insight in to the experience of health anxiety needs to be developed.

Recently, research has moved away from the label of hypochondriasis, a label largely perceived to be pejorative and associated with malingering (Abramowitz & Braddock, 2008). Instead, literature now tends to use the term 'health anxiety.' The concept of health anxiety refers to those who worry about having a serious illness/disease. Health anxiety is not a clinical diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association, 2013). Rather, it is conceptualised as a spectrum of symptoms

embodying disproportionate fears around health and illness, running on a continuum from mild concerns to severe (Asmundson et al., 2001; Abramowitz & Braddock, 2008). To clarify, health anxiety is the current explanation for what was once known as 'hypochondriasis.' Most of what we know about health anxiety has; however emerged from literature on hypochondriasis (Abramowitz & Braddock, 2008). As such, the terms will be used interchangeably throughout this piece. It is pertinent to acknowledge the risks of doing this, with some of these terms being inherently pathologising.

Our understandings of how this phenomenon presents in the community are limited. When the full Diagnostic Statistical Manual criteria (DSM-IV) of hypochondriasis are applied, community prevalence sits at around 0.04% (Bleichhardt & Hiller, 2007; Looper & Kirmayer, 2002; Martin & Jacobi, 2006). Exact prevalence rates in New Zealand have not yet been identified, but it is anticipated that they sit around the same as those found in general population studies. With less restrictive criteria, it is estimated that the prevalence will be around 1%, suggesting that the diagnostic focus of this disorder excludes a proportion of people who associate with some of the concerns experienced in health anxiety (Starcevic & Noyes, 2014). Therefore, research has found relatively low rates of diagnosable hypochondriasis in the community, but has found that significant illness worry or health related worry is relatively common (Noyes Jr, 2005). As such, it appears that the diagnoses may be failing to provide insight into the idiosyncrasies and nuances of this disorder (Abramowitz & Braddock, 2008).

In a study by Looper and Kirmayer (2002), only one of their 533 participants from a community sample in the United States met the full criteria for DSM-IV

hypochondriasis. This finding indicates that few people in the community meet the full diagnostic criteria as outlined by the DSM-IV. A number of other studies have also found that few people meet the full criteria for hypochondriasis but that larger numbers fall within the subthreshold of these syndromes (García-Campayo et al., 1998; Kirmayer & Robbins, 1991; Martin & Jacobi, 2006; Noyes Jr, 2005). This indicates that when health anxiety is explored as a continuum, with 'normal' illness worry on one side and DSM-IV hypochondriacal worry on the other, more people identify as having health anxiety (Noyes, 2005). This is significant, as research has demonstrated that even mildly elevated health anxiety levels are associated with decreased quality of life, increased health care utilization and are a putative risk factor for more severe health anxiety (Ferguson, 2009).

Most of the research in the field of health anxiety has been conducted on clinical populations. Research tends to use the International Classification of Diseases (ICD-10) and DSM-IV criteria when screening participants. However, as discussed, it is apparent that a larger proportion of people are more likely to have subthreshold levels of health anxiety. As such, it is important to build an evidence base for this population, as using diagnostic criteria may be too restrictive and will likely exclude a large proportion of people who excessively worry about their health. Furthermore, data suggests increasing rates of psychological distress in New Zealand, increasing from 7.6% in 2016/17 up to 8.6% in 2018 (Mental Health Inquiry, 2018).Therefore, it is important that we work to increase our understanding of health anxiety within New Zealand. Improved understandings of the lived experience of health anxiety will help to facilitate understandings of best treatment practice for both New Zealand and other comparable countries.

The experience of worrying about one's health is still largely unstudied and recent shifts in definitions and understandings of it suggest the necessity of further research into this area. In particular, there is an absence of qualitative research in this area. Qualitative research proves crucial to gain insight into the experiences of those who experience anxiety around their health. It provides information regarding experience and perspective, and rich descriptions to help develop theories and hypotheses (Sofaer, 1999). Prior qualitative research has been largely focused on specific research questions such as use of the internet and relationships with health professionals. In order to gain better understanding of health anxiety, more inductive research is needed, looking into the experience of people who suffer with anxiety around their health.

Chapter Outline

Chapters 1 through 5 outline the relevant literature in this field. These chapters explore the changing understandings of health anxiety across time, current models of health anxiety, literature examining how people attempt to cope with their worries and the interactions of people with health anxiety with health care services.

Chapter 6 describes the methodology followed in the present study. It explores the rationale for this study referring to gaps in the literature in this field. This chapter places the research within its theoretical context. The inclusion and exclusion criteria for this study are also outlined as well as information regarding the participants included in the study. This chapter also details the interview process.

Research findings are discussed and analysed through Chapter 7 which examines the findings through six core themes and their relevant subthemes. These themes are considered in the methodology.

Chapter 8 presents the conclusions of this study as well its limitations. This chapter also suggests directions for future research in this field.

Chapter 2: Hypochondriasis or Health Anxiety? Developing Diagnoses

The concept of health worry has been recognised and discussed for at least 2000 years, but understandings of this experience continue to develop (Starcevic & Lipsitt, 2001). We can track the influence of the changing social context on our accounts of health anxiety, with understandings being shaped by dynamic social forces such as class, gender and institutional structures (Brown, 1995). As most of the research in this field has explored this phenomenon through a diagnostic lens, it is important to discuss the biomedical framework for health anxiety. Again, attention should be drawn to the interchangeable use of health anxiety and hypochondriasis in the literature. This chapter will outline the developing diagnoses of health worry from its origins approximately 2000 years ago, to its changing conceptualisation within the Diagnostic Statistical Manual (DSM). This chapter will also explore the emerging awareness of 'mental health worry' and some notable overlapping diagnoses.

Hypochondriasis Emerges

Hypochondriasis or hypochondria first appeared in the fourth to fifth century BC as an anatomical word. Hippocrates, a Greek physician, introduced the term 'hypochondriac', relating to a disorder below the cartilage of the ribs (Bound, 2006). This region was identified as the source of black bile. Excessive amounts of this bile was believed to cause difficulties in both mind and body (Bound, 2006) Hypochondria was only applicable to men at this time, with women instead diagnosed with 'hysteria.' Hysteria in women was believed to be caused by a 'restless womb' which, when they were seeking sexual gratification, could cause symptomatology

such as respiratory distress, extravagant emotional behaviour, motor paralyses, sensory loss and dizziness (Micale, 2008). Treatments for hysteria included regular marital sex and uterine fumigations (Micale, 2008). As such we can see the early gendered conceptualisation of this disease.

This view of hypochondria was predominant until the mid-sixteenth century. Subsequent understandings of this disorder associated it with melancholia (mental and affective symptoms of depression), but understandings of the disorder seem confused and ambiguous (Dillon, 2010). From the beginning, the diagnosis of hypochondria was uncertain and controversial (Noyes Jr, 2005).

One of the most influential understandings of hypochondria comes from Robert Burton, an English scholar and Anglican Clergyman. In his *The Anatomy of Melancholy* (1621), the 'hypochondries' were placed within the jurisdiction of melancholy. The book's frontispiece provides an interesting insight into perceptions of hypochondria in this era. The frontispiece illustrates the several versions of melancholia at this time: Solitudo (representing jealously and solitude), Inamorato (representing victims of love melancholy), Superstititosus (representing victims of superstition), Maniacus (representing victims of madness) and Hypochondriacus (Burton, 1621). According to Burton, Hypochondria is the most "grevious and frequent" of all melancholy (Burton, 1621). The frontispiece depicts the Hypochondriacus patient lounging in furs, staring blankly towards medicine bottles, drinking cups and what appear to be apothecary prescriptions.

Figure 1.

The Anatomy of Melancholy, Burton (1621)

5 Hyponchondriacus leans on his arm,

Wind in his side doth him much harm,

And troubles him full sore, God knows,

Much pain he hath and many woes.

About him pots and glasses lie,

Newly brought from's Apothecary.

This Saturn's aspects signify,

You see them portray'd in the sky

Burton drew from Hippocrates's understandings of hypochondriasis, attributing the causes hypochondriasis to the abdominal area, the "wind in his side", conceptualising hypochondria primarily as a physical disease (Heath, 2011). Burton associated the "hypochondriacal melancholy" with common symptoms such as 'belching', 'heat in the bowels' and 'turbulent dreams.' Burton's account of hypochondrium stems from the theory of humours, in which any psychological effects present are caused by an excess of black bile (Heath, 2011). Factors such as poor diet and excessive work, could allow this black bile to rise up from the abdomen and corrupt the brain (Bound, 2006). Not long after Burton, Thomas Willis's (1621-1675) writings in The London practise of physic (1685) replaced Burton's humoral understanding with one based on the brain and the nerves, leading the seventeenth century to reconsider hypochondriasis as a nervous disorder, caused by contractions

and convulsions of the nervous parts (Heath, 2011). The seventeenth century also saw a movement to acknowledge similarities between hypochondria and the traditionally female disorder of hysteria, with prominent scholars such as Thomas Willis deeming both hypochondriasis in men and hysteria in women to be disorders of the brain (Heath, 2011).

Towards a Psychological Understanding

The beginning of the eighteenth century saw the development of a psychological understanding of hypochondria, spearheaded by Sir Richard Blackmore, author of *A Treatise of the Spleen and Vapours: or, Hypocondriacal and Hysterical Affections* (1725). Blackmore argued for the separation of melancholia and hypochondriasis, describing melancholia as a more serious pathology, and placing hypochondriasis as a milder concern (Noyes, 2011).George Cheyne's *The English Malady* (1733) argued that ill health was caused by a "weakness of nerves." Cheyne argued that in particular the English, and those of greater intelligence and higher social standing, were more prone to hypochondria, as a result of factors such as the rich food, sedentary occupations, populous towns and the moist air (Cheyne, 1733).

The nineteenth century was identified as the era in which hypochondriasis began to be classified as a mental disorder (Noyes, 2011). Prior to this period people expected to suffer from various diseases throughout their lifetime, many of which could prove fatal (Noyes, 2011). The enlightenment era reflected change in society, giving people renewed hope for medical cures and longer life span (Noyes, 2011). This period saw an increase in the provision of health care services with increasing numbers of hospitals. The psychiatrist Russel Noyes Jr (2011) argued that this source of hope for a longer lifespan may have cultivated hypochondriacal concerns. Noyes

(2011) also argued for the significance of this period in shifting the power dynamic between patient and doctors. Doctors in the new hospitals began to be recognised as the 'elite' wielding power over the lower classes as a result of their ability to provide potential cures. This period also saw the shift towards the physical exam, using equipment such as stethoscopes, changing the relationship from an active to a passive one, serving to further strengthen this emerging power dynamic (Noyes, 2011).

This period changed the focus of hypochondriasis towards the psychological. Hypochondriasis had no apparent organic cause and consequently became redefined through psychological terms (Noyes, 2011). In the nineteenth century depressive symptoms, often described as the 'melancholy', were starting to be seen as secondary by physicians (Noyes, 2011). Physicians frequently noted psychological causes or mechanisms, with aspects such as 'sensitivity of the nerves' being considered in understandings of hypochondriasis (Noyes, 2011). In this period hypochondria covered a disorder ranging from people being 'over-sensitive' to insanity with delusions and suicidality (Heath, 2011). Treatment began to focus on tools such as distraction, and using tactics such as moderate exercise (Noyes, 2011). Although attention had begun to shift, hypochondriasis became regarded as a neurosis, a term used to describe a relatively mild mental illness that is not caused by organic disease. At the end of the nineteenth century, the Austrian psychoanalyst Sigmund Freud began to describe hypochondriasis as an 'actual neurosis', meaning a neurosis that has a physical basis. Freud argued that hypochondriacal patients direct their libido inwards, instead of externally, and as such this internally directed libido results in physical symptoms (Freud, 1956). These understandings dominated much of the understandings of hypochondriasis in the twentieth century.

By the end of the twentieth century more specific cognitive-behavioural models were introduced that focused more on the misinterpretation of bodily sensations (Dillon, 2010). The 1960s saw the psychiatrist Issy Pilowsky (1967) introduce the concept of an 'abnormal illness behaviour.' He used this term to classify syndromes that had described an excessive or inadequate response to symptoms, such as hypochondriasis. In response Pilowsky (1967) developed the first self-report measure to identify hypochondriasis, the Whitley Index (WI). His initial factor analysis for this measure showed three key aspects of this abnormal illness behaviour: a) bodily preoccupation, a concern with somatic symptoms b) disease fear and c) disease conviction, belief in illness despite evidence to the contrary. These findings formed the basis from which hypochondriasis was defined in the DSM-III (Pilowsky, 1967).

Health Anxiety in the DSM

This section will explore the journey of health anxiety through its changing nature in the DSM. A summary of the diagnostic criteria from DSM III to DSM-IV is provided in Appendix B.

DSM-II

'Hypochondriacal Neurosis' was the first diagnostic recognition of health anxiety appearing in the DSM–II in 1968 (American Psychiatric Association, 1968). 'Hypochondriacal Neurosis' was characterized as a "preoccupation with the body and with fear of presumed diseases of various organs" that persists "despite reassurance" (American Psychiatric Association, 1968,p.41).

DSM-III and DSM-III-R

The introduction of the DSM-III meant the rise of descriptive psychiatry. Descriptive psychiatry intentionally distanced itself from the psychoanalytic language of previous editions of the DSM. Instead, diagnosis began to be conceptualised through research and biology. The DSM-III presented hypochondriacal neurosis as characterized by unrealistic interpretations of physical signs. The DSM-III also defined the symptom of preoccupation with the fear of having an illness and also introduced a minimum duration of six months. Diagnosis of hypochondriacal neurosis would not be made if the symptoms could be better accounted for by another disorder, such as major depression or schizophrenia. However, the revised DSM-III (DSM-III-R) released seven years later further defined the criteria. This edition did allow for the diagnosis of other disorders, provided that the symptoms are not solely explained by the other disorder.

DSM-IV and DSM-IV-TR

Table 1(Appendix B) has both DSM-IV and DSM-IV-TR criteria together as there were no changes made for the diagnostic criteria for hypochondriasis. The criteria that the individual must have a preoccupation with fears of having, or the idea that one has a serious illness based on a misinterpretation of bodily symptoms was preserved. Additional criterion were added for clarification of exclusionary criteria for overlap with other mental disorders (e.g., panic disorder, obsessive compulsive disorder). According to the DSM-IV, in hypochondriasis, disease conviction is associated with a preoccupation that they have a serious disease, despite reassurance

from health professionals that there is no evidence of serious disease (American Psychiatric Association, 1968).

DSM 5

The diagnosis of hypochondriasis fell out of favour in the latest edition of the Diagnostic Statistical Manual (DSM5), with many people viewing the diagnosis of hypochondriasis as too restrictive and stigmatising (Newby et al., 2017). Primary care practitioners found somatic disorders hard to apply in primary care, with some being so arbitrary that they overlap and some so restrictive that they are impossible to apply (Fink et al., 2004). Over recent years, the American Psychological Association has moved away from the diagnosis of hypochondriasis. The movement away from hypochondriasis has resulted from its pejorative symptomatology, and the large stigma attached to the terms 'hypochondriasis' and 'hypochondriac.'

Health anxiety is not a clinical diagnosis per se, so it does not appear as its own diagnosis in the DSM-5. The creation of the DSM-5 saw the diagnosis of 'hypochondriasis' replaced by two new diagnostic criteria: Somatic Symptom Disorder (SSD) and Illness Anxiety Disorder (IAD). SSD incorporated a number of somatoform disorders previously included in the DSM-IV(somatization disorder, pain disorder, hypochondriasis, undifferentiated somatoform disorder). According to the DSM, individuals diagnosed with SSD present with somatic symptoms, plus abnormal thoughts, feelings, and behaviours. They also may or may not have been diagnosed with a medical condition (American Psychiatric Association, 2013). IAD applies to individuals who also experience health anxiety, but without somatic symptoms. The DSM5 proposes two main subtypes for IAD, these are care-seeking type and care-avoidant type. Care seeking type is a person who seeks out medical

assistance and care, whereas those who are care avoidant rarely seek out any medical care (American Psychiatric Association, 2013). The term 'health anxiety' is often used broadly when explaining these two conditions.

Somatic Symptom Disorder (SSD) vs. Illness Anxiety Disorder (IAD)

People with IAD are distinguished from those with SSD due to their focus on *thoughts* that they are unwell, whilst those with SSD more focused on the somatic symptoms. Patients with IAD demonstrate their distress not by focusing on somatic symptoms, but on the potential consequences of their worries and the meaning that this has on their life (Almalki et al., 2016). Both concerns can exist in each disorder to a varying degree, though patients with IAD usually complain about fewer somatic symptoms than those with SSD (Sadock et al., 2014). Research has also suggested that SSD usually has an onset before age 30, whereas IAD has a less specific onset (Sadock et al., 2014).

A recent study by Newby et al. (2017) investigated the reliability, validity and utility of the DSM-5 diagnoses of SSD and IAD. Of their 118 participants with health anxiety, 47.5% met criteria for IAD, 44.1% met criteria for SSD, and 8.5% for comorbid IAD and SSD. Their research suggested that participants with SSD had more functional impairment and more comorbid disorders overall than those diagnosed with IAD. The results also showed that there was no difference in demographics between those diagnosed with IAD and those with SSD. Therefore, their results suggest that the differences between these two subtypes are in fact related to severity (Newby et al., 2017). Unlike Newby et al. (2017), Bailer et al. (2016) found that their participants were predominantly diagnosed with SSD (74%) with only the minority diagnosed with IAD (26%). However, like Newby et al. (2017),

they did find that participants diagnosed with SSD were more impaired with more comorbidities and more medical consultations than those with IAD. Bailer et al. (2016) argued that the differences between the two diagnoses are more quantitative (e.g., SSD appears more severe, presenting with correlates like more somatic symptoms and more visits to healthcare providers). Consequently, Newby et al. (2017) argue that the introduction of these two diagnoses has done little to improve clarity from the prior diagnosis of hypochondriasis.

Table 2.

DSM 5 Criteria for Illness Anxiety Disorder (IAD) Somatic Symptom Disorder (SSD)

Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5) Criteria for Illness Anxiety Disorder	**Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5) Criteria for Somatic Symptom Disorder**
A. Preoccupation with having or acquiring a serious illness	A. One or more somatic symptoms that are distressing or result in significant disruption of daily life
B. Somatic symptoms are not present or, if present, are only mild in intensity. If another medical condition is present or there is a high risk for developing a medical condition (e.g., strong family history is present), the preoccupation is clearly excessive or disproportionate.	B. Excessive thoughts, feelings or behaviours related to somatic symptoms or associated health concerns as manifested by at least one of the following: 1. Disproportionate and persistent thoughts about the seriousness of one's symptoms 2. Persistently high level of anxiety about health or symptoms 3. Excessive time and energy devoted to these symptoms or health concerns
C. There is a high level of anxiety about health, and the individual is easily alarmed about personal health status.	C. Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months)
D. The individual performs excessive health-related behaviors (e.g., repeatedly checks his or her body for signs of illness) or exhibits maladaptive avoidance (e.g., avoids doctors appointments and hospitals).	

Mental Health Anxiety

People can experience extensive and enduring worry about their mental health concerns in a similar way to those who worry about their physical health (Commons, Greenword & Anderson, 2016). As such recent conceptualisations of health anxiety have built on established models of health anxiety to include anxiety around mental health (Commons et al., 2016). Common mental health concerns include concerns surrounding becoming institutionalised or losing control (Rachman, 2012). Rachman (2012) argued that there are aspects of mental health anxiety that appear to be compatible with the cognitive model of health anxiety (to be discussed later) namely causal factors, triggers and beliefs.

There is a noticeable scarcity of research exploring mental health anxiety. Commons et al. (2016) conducted a preliminary investigation into a new Mental Health Anxiety Inventory (MHAI) measure. They used the MHAI and a modified version of the Short Health Anxiety Inventory (SHAI) to explore anxiety regarding mental health. This MHAI measure includes questions such as "I spend much of my time worrying about my mental health" and "I am always afraid that I have a serious mental illness." Their results indicated that people worry about their mental health just as much as they do about their physical health, indicating the importance of including mental health measures in explorations of health anxiety.

Bassett et al. (2009) investigated a fear of madness in individuals with persecutory delusions. This study used their newly developed Worries About Mental Health (WAMH) questionnaire, intended to capture different manifestations of the fear of madness (Bassett et al., 2009). This measure includes items such as "I worry

my mind is falling apart" and "I fear I will go mad." Their results demonstrated that their participants with persecutory delusions had greater fear of madness than their non-clinical controls (Basset et al., 2009). Interestingly, Basset et al. (2009) reported that those with persecutory delusions reported significantly higher levels of anxiety around madness that made their experience of persecutory delusions more intense. Potentially, in the same way that focus on somatic symptoms can amplify their somatic sensations, a focus on persecutory delusions may be amplifying them.

Rise of Descriptive Psychiatry

Many have argued that the introduction of the third edition of the Diagnostic Statistical Manual (DSM) in the 1980s represented a significant reframing of the biopsychosocial model. The introduction of the DSM-III saw a move towards a more descriptive explanation of behaviour and symptomatology (Wilson, 1993). In the post-war years, the key models in psychiatry were psycho-dynamically based, focused on understanding what the symptom meant rather than how it can be understood through medical models (Wilson, 1993). However, towards the 1960s and 70s there was a drive for a more structured diagnostic framework, to more clearly demarcate the boundaries between medicine and psychiatry and to demarcate the well from the sick (Wilson, 1993). The DSM-III was an attempt to make mental illness more explicit and structured, in a bid to make assessments and treatment more reliable (Wilson, 1993).

According to Nikolas Rose, a prominent sociologist, this move towards more rigid boundaries of mental health means that "doctors have lost the monopoly of the diagnostic gaze" (Rose, 2007, p.11). Instead of being able to use clinical judgment, doctors are expected to work through within these constructed boundaries of mental

health. Clinical judgment has become more controlled. Arguably this diagnostic focus has diminished the individual and idiosyncratic experiences of people. Thus, there is a need to move away from these diagnostic categories in a means to explore the depth of experience for people suffering with anxiety surrounding their health.

Overlapping Diagnoses

As discussed, health anxiety is not an official diagnosis, but a term to represent a combination of symptoms featuring preoccupied fears about health, disproportionate anxiety and excessive behaviours such as avoidance and checking (Abramowitz & Braddock, 2008). Health anxiety appears to have a high rate of comorbidity with other anxiety disorders, and thus the diagnosis can be complex to differentiate. Excessive concerns about one's health can appear in a number of anxiety disorders, such as generalised anxiety disorder (GAD), obsessive compulsive disorder (OCD), specific phobia and panic disorder (PD).

For example, fear of losing control or going crazy is listed as a potential symptom of panic disorder (Commons et al., 2016). Similarly, in OCD intrusive thoughts can contain content where the person believes that they may be mad or bad (Rachman, 2012). A study by Scarella et al. (2016) investigated whether health anxiety is better considered as its own diagnosis, or whether in fact it should considered as a secondary feature of other disorders. Their results suggested that their participants who had clinical levels of health anxiety exhibited a high level of comorbidity with other psychiatric conditions, with the highest rate of comorbidity being anxiety disorders. The results found that 28.5% of participants also had GAD, 14.4% had PD and 12.9% also had OCD. Despite these high levels of comorbidities, there was a high occurrence of health anxiety in the absence of another psychiatric

condition. Therefore their results indicate that health anxiety should be considered a separate entity to other psychiatric concerns (Scarella et al., 2016).

There has been substantial debate over whether health anxiety should be considered to be an anxiety disorder due to its similar symptomatology with other anxiety disorders. However, there are some noticeable differences. Unlike people who present with health anxiety as the primary concern, those with GAD often have additional areas of worry such as finances, relationships and the potential for disaster, as well as possible concerns about their health and the content of their worries can often shift between different areas (Bailer et al., 2016). Like people who suffer from health anxiety, people suffering with OCD can also become preoccupied with concerns about their health, with these worries often revolving around compulsive checking and reassurance seeking. However, those with health anxiety often exhibit more fears of bodily sensations, and appear to demonstrate less insight than people with OCD (Abramowitz & Braddock, 2006).

Conversion disorder (also called Functional Neurological Symptom Disorder) in the DSM5, is when the patient presents with neurologic symptoms such as blindness or deafness, which appear to have no organic cause, and symptoms are preceded by some conflict or psychological distress. The patient is not malingering, or intentionally causing these symptoms. Conversion disorder is usually temporary and involves focus on a symptom rather than a specific disease.

Chapter Summary

Over the past 2000 years we can observe the shifting in understanding of the phenomenon of health anxiety. In particular, one can identify the direct influence of social processes in re-shaping our conceptualisations of this experience. For example,

we can see the influence of conceptualisations around gender in shaping early understandings of health anxiety, a diagnosis viewed as mostly exclusive to women. Moreover, we can see the influence of social processes on changing the labelling of the disorder, with its move away from the stigmatised label of hypochondriasis. Additionally, we can see the influence of the emergence of descriptive psychology on shaping perceptions of health anxiety, crafting this experience through diagnostic labels and symptoms, bringing light to the significance of social processes on shaping our medicalised understandings of this experience. Thus, it is critical that the experience of health anxiety is explored within its social context.

Chapter 3: Models of Health Anxiety

The two most well recognised and researched psychological models of health anxiety are the cognitive model and the interpersonal model. The focus of academic research on these models has meant that they have provided the foundation for the way in which understandings of the experience of health concerns have been shaped and understood in the literature so far. These models also provide the dominant lens through these experiences are explored in psychotherapy. Accordingly, it is vital to provide this critical review so as to be able to provide a context to which later to compare and contrast participants' accounts. This chapter will critically explore these two models as well as their relevant treatment protocols.

The Cognitive Behavioural Model

The cognitive behavioural hypothesis of health anxiety proposes that people who suffer from health anxiety have an enduring tendency to focus on information around their health. This information can come from their own experience of bodily sensations or outside information around health. For health anxious people, this information, be it internal or external, is often interpreted as evidence of serious illness (Scarella et al., 2016). The cognitive behavioural model of health anxiety was founded on Aaron Beck's (1976) cognitive model of emotion. Beck's (1976) theory argues that the emotions that we experience are shaped by the way that we appraise situations; that the meaning that we give to an event is what triggers emotions, rather than the event itself. This model argues that situations we experienced early in life can lead us to develop assumptions that some situations are more dangerous than they really are (Beck, 1976).

Paul Salkovskis and Hilary Warwick (1986) extended the cognitive model to account for health anxiety. This model proposes that those with health anxiety tend to perceive bodily sensations and illness information as more dangerous than they really are (Salkovskis, 1996). According to this model, when a person misinterprets this information its impact varies as a result of four factors; perceived likelihood of illness, perceived cost, awfulness and burden of illness, perceived ability to cope with illness and perception of the extent to which external factors will help (Salkovskis & Warwick, 2001). An individual with health anxiety is likely to perceive the illness as more probable than it is, and to perceive themselves as unable to prevent the illness or its course, and believing they have no effective means to cope with it.

The cognitive model proposes that health anxiety develops from past experiences of illness either in oneself or in others. This experience leads to the formation of negative or rigid assumptions around illness, which are known as dysfunctional core beliefs (Salkovskis & Warwick, 2001). Research has shown that health anxious people view 'good health' as an absence of any symptoms (Barsky et al., 1991). When a health anxious person begins to experience symptoms such as body aches or chest pain, their underlying dysfunctional beliefs surrounding what good health is may cause catastrophic interpretations. Dysfunctional health beliefs (e.g., this chest pain means I must have heart disease) can be activated through internal cues such as physical symptoms (e.g., abnormal bodily sensations), or external (e.g., experience of illness in the family or exposure to negative media) (Singh et al., 2016b). According to the cognitive model, the threat can be specific such as, I will develop skin cancer or I have skin cancer, or a broader concern surrounding many aspects of health.

Within the cognitive model, there are three ways in which we acquire these fears and in turn, how we may acquire these dysfunctional beliefs, namely: by experiencing emotionally disturbing events, through an experience faced by a relative or close friend, or by absorbing threatening information, through means such as the media (Rachman, 2012). A study by Noyes et al. (2005) found that traumatic childhood events such as death of a family member were reported significantly more often by patients diagnosed with hypochondriasis, than patients without a diagnosis. Their results indicate these experiences may create dysfunctional beliefs, such as a high level of worry about illness (Russell Noyes et al., 2005). Health anxiety can manifest affectively in a number of ways, often presenting as high levels of anxiety, depression and anger. Individual's cognitions become focused on their perceived illness. Like other anxiety disorders, health anxiety can cause a number of behavioural changes such as reassurance seeking from medical professionals and checking one's body for signs of 'abnormality' (Salkovskis, 1996).

Anxiety Sensitivity and Intolerance of Uncertainty

Two factors that are consistently associated with health anxiety within the cognitive model are anxiety sensitivity (AS) and intolerance of uncertainty (IU). These two factors are thought to contribute to the prediction of health anxiety (Fergus & Bardeen, 2013). Anxiety sensitivity refers to the fear of arousal related sensations (e.g., racing heart). This fear results from cognitions around the perceived meaning and consequences of the arousal related sensations (Rachman, 2012). Anxiety sensitivity is thought to amplify anxiety, where individuals with high anxiety sensitivity tend to experience amplified arousal related sensations as a result of their focus on them (Horenstein et al., 2019). Research suggests that individuals with

elevated levels of health anxiety have higher levels of anxiety sensitivity (Horenstein et al., 2019). Intolerance of uncertainty refers to the dispositional fear of the unknown (Horenstein et al., 2019). For individuals with high IU, uncertainty is particularly daunting and often results in a tendency for those with high IU to find ambiguity particularly distressing (Koerner & Dugas, 2008). It is anticipated that individuals who find ambiguity particularly distressing are more likely to engage in reassurance seeking behaviours (Horenstein et al., 2019).

Both of these factors have shown strong associations with health anxiety across numerous studies (Horenstein et al., 2019). Research has also indicated that although these concepts are individual, they are related in the prediction of health anxiety. It has been suggested that IU represents difficulty with uncertainty in a more general sense, whereas AS reflects a specific fear to the uncertainty of physical sensations (O'Bryan and McLeish, 2017). A recent study proposed a model in which IU was indirectly associated with AS through the domain of physical concerns (O'Bryan and McLeish, 2017). O'Bryan and McLeish (2017) hypothesised that inability to tolerate uncertainty impacts the inability to tolerate uncertainty in regards to physical sensations, and the meaning and potential consequences of these sensations (O'Bryan & McLeish, 2017). Catastrophic thoughts towards these physical sensations ultimately therefore leads to higher levels of health anxiety (O'Bryan & McLeish, 2017). Similar, a recent study by Horenstein et al. (2019) found that for participants with higher levels of both IU and AS, there were greater odds of at least one medical visit in the past six months, demonstrating the influence of these two factors on healthcare utilization.

Both AS and IU have been associated with frequent use of the internet to search for medical information (Fergus, 2015; Norr et al., 2014). Norr et al. (2014) investigated whether viewing medical websites would adversely affect anxiety sensitivity. Participants were randomly assigned to view websites relating to medical symptoms, or control websites reflecting health and wellness. Anxiety sensitivity was measured before and after viewing the websites. Individuals in the medical website group reported higher AS compared to controls, but only those participants with high IU, suggesting the interacting effect of these two factors on increasing anxiety (Norr et al., 2014). As such the findings indicate that exposure to medical information could increase anxiety sensitivity for those with a higher level of intolerance of uncertainty. These findings indicate the importance of the interaction between anxiety sensitivity and intolerance of uncertainty in predicting health anxiety.

Interpersonal Model

Whilst the cognitive model of health anxiety posits that health beliefs contribute to health anxiety, the interpersonal model specifies the importance of that attachment in the aetiology of health anxiety. The interpersonal model of health anxiety (IMHA) argues that health anxiety results from insecure attachment. According to this theory, people with insecure attachment have persistent concerns that they will be rejected or abandoned by significant others (Alberts & Hadjistavropoulos, 2014). It posits that health anxiety is a pathological manifestation of negative early childhood experiences (e.g., illness) and negative relationships with caregivers (Sherry et al., 2014). The focus for the IMHA is not on one's cognitions, but rather on their attachment style. According to this model, a person's repeated concerns around illness allow them to gain support, care and reassurance from the

people around them, which helps to reduce their attachment anxiety (Stuart & Noyes, 1999). Subsequently, their repeated searches for reassurance ultimately lead to a rejection by those meant to provide them with care (Stuart & Noyes, 2005).

This theory characterizes health anxiety in three elements. The first of these is the persistent belief that a physical illness is present despite medical evidence to the contrary. The second is a failure to respond to interpersonal reassurance that the illness does not exist. The third and final is the expectation that people with health anxiety have poor insight. In this theory, people with health anxiety are unaware that their belief does not fit with the objective evidence and are unaware that their failure to respond to medical reassurance is driving medical care away.

In the IMHA, health anxiety is maintained through repeated reassurance seeking, where individuals seek reassurance from others in a bid to gain a sense of comfort and security (Anagnostopoulos & Botse, 2016). This becomes particularly prominent during times of stress, where the individual often increases these care-seeking behaviours (Stuart & Noyes, 1999). When this reassurance seeking becomes excessive, as it often does with health anxiety, people begin to distance themselves from the individual with health anxiety (Birnie et al., 2013). This rejection serves to solidify the individual's attachment anxiety, and drives the individual to believe that their concerns have been ignored, and thus the cycle of reassurance seeking begins again (Birnie et al., 2013).

Insecure attachment style has been shown to be a risk factor for a variety of disorders, but it has been suggested that childhood experience with illness is a significant risk factor for health anxiety (Muse et al., 2012). The model hypothesizes that those who demonstrate somatising behaviours have experienced profound

childhood experiences that have impacted their attachment style (Noyes et al., 2003). In the same way as the cognitive model for health anxiety, the IMHA argues that childhood experience of illness, such as watching a parent battle cancer or suffering from an illness themselves as a child can predispose a person to somatization. In line with this, there is a significant amount of literature looking at the influence of childhood illness on the development of health anxiety (Stuart and Noyes, 1999). Bass and Murphy (1995) found that long term exposure as a child to parental disability had interfered with half of the participants' parent's ability to provide care to them as children. Furthermore, they found that 20% of the somatising sample had experienced chronic illnesses such as rheumatic fever and asthma before the age of 16, meaning that they had regular contact with health services throughout their childhood (Bass & Murphy, 1995).

The IMHA also argues that *traumatic* childhood experiences can contribute to the development of health anxiety. A substantial amount of research in this area also suggests that childhood abuse can be a risk factor for health anxiety (Noyes et al., 2003; Waldinger et al., 2006). A study by Reiser, McMillan, Wright, & Asmundson (2014) explored the connection between negative childhood experiences such as neglect, sexual abuse and substance use in the home, with levels of health anxiety. Their results suggested positive associations between these negative experiences and health anxiety, finding that the more negative childhood experiences there were, the higher the levels of health anxiety (Reiser et al., 2014).

The interpersonal model of health anxiety depicts a transactional model of the interactions with physicians and health care providers. According to this model, health anxious patients most commonly present to a primary care physician who

typically attempts review their symptom concerns using medical examination (Williams et al., 2010) . Patients are often reassured when no physical cause is found for these symptoms, but this often only provides short-term relief. Over time, the physician comes to realise that these patients are repeatedly presenting with medically unexplained symptoms. This model argues that physicians often become critical of these patients, due to a view that emotional concerns are not legitimate topics for medical visits leading to strained relationships between the physician and the patient (Williams et al., 2010). As such, this model argues for the pertinent role that health care providers play in the treatment of health anxiety and perhaps its need to be included in treatment (Lipsitt, 2001)

Treatment

It is unclear how hypochondriacal patients are being cared for in New Zealand. Most hypochondriacal patients present with a physical ailment and therefore are most commonly looked after by their primary care provider, most likely their GP. Service users report mental health care notoriously difficult to access with limited resources (Mental Health Inquiry, 2018). In particular, people report concerns that their difficulties are not viewed as 'serious' enough to warrant psychological support (Mental Health Inquiry, 2018). Accordingly, further research needs to explore the treatment of health anxiety from a New Zealand perspective.

Medication

As for most anxiety issues, anti-depressants, particularly selective serotonin reuptake inhibitors (SSRI), appear to be the most popular treatment for health anxiety. The research on the use of pharmaceuticals for health anxiety is limited but suggests the efficacy of anti-depressant medication in combination with CBT. A study by

Greeven et al. (2009) found that both CBT and paroxetine (an SSRI) were effective at reducing health anxiety symptoms. Their results showed no significant differences between paroxetine and CBT (Greeven et al., 2009). Fallon et al. (2008) assigned 57 patients with health anxiety to a fluoxetine (an SSRI) or placebo group. Their results showed that after six months the improvements made by patients taking fluoxetine (an SSRI) was maintained(Fallon et al., 2008) . A recent study found that fluoxetine was the primary treatment contributing to improvement in participant's symptoms, when compared to cognitive behavioural therapy, a combination of CBT and fluoxetine and a placebo group (Fallon et al., 2017).

CBT

The CBT approach to treatment of 'excessive' health concerns, emphasizes the role of dysfunctional beliefs in maintaining health anxiety (Olatunji et al., 2014). The cognitive restructuring in the CBT framework often involves examining illness-related thoughts, appraisals of somatic symptoms and relaxation training (Stuart et al., 2008). Research has suggested that people with 'excessive' concerns about their health have a preference for psychological treatments over pharmaceutical treatments, so the efficacy of these treatment methodologies is pertinent.

A study by Walker et al., (1999) with 23 community patients with diagnoses of health anxiety reported that participants predicted CBT to be more effective relative to medication. It was also viewed as more acceptable than the medication alternative(Walker et al., 1999) . A study by Barksy and Ahern (2004) of primary care patients and volunteers with health anxiety, compared CBT treatment to medical care as usual for 187 participants. Participants in the CBT condition had six individualized sessions of CBT. Their results showed that at 6 and 12 month follow-

up CBT patients had significantly lower levels of hypochondriacal symptoms, beliefs and attitudes (Barsky & Ahern, 2004). More recently, a meta-analysis by Olatunji et al. (2014) explored the efficacy of CBT for health anxiety in 13 studies. Their results suggested improvements for hypochondriacal symptoms but also for depressive symptoms which can often present comorbidly with health anxiety symptoms.

A series of randomised control trials have also shown the efficacy of internet delivered CBT (iCBT) for health anxiety(Hedman et al., 2011, 2016; Newby et al., 2020). In a recent study by Newby et al. (2020) 391 patients were prescribed an iCBT course consisting of six online sessions by their clinician in the community. Their results showed that on average, participants demonstrated large and significant reductions on all outcome measures of health anxiety, comorbid depression symptoms and general distress (Newby et al., 2020). However, until recently there had been no meta-analysis exploring critical factors in treatment efficacy such as remission and varied delivery formats such as the internet (Axelsson & Hedman-Lagerlöf, 2019). Hence, evidence of the efficacy for this treatment protocol is still in its infancy.

Interpersonal Psychotherapy

Interpersonal Psychotherapy (IPT) is a manualized psychotherapeutic programme that is time-limited (Stuart & Noyes, 2005). This treatment focuses on the importance of interpersonal difficulties in health anxiety and the role of attachment behaviour in this. In IPT, attachment behaviour is seen as inherently linked to care seeking behaviour, where people seek to evoke responses from others in order to relieve their distress (Stuart & Noyes, 2005). The responses from others either serve to relieve or enhance a person's anxiety and care-seeking behaviour.

Accordingly, IPT is designed to address this care-seeking behaviour using methods such as improving communication, understanding the patient's perspective, and empathy (Stuart & Noyes, 2005). It works to help the patient to develop and better utilize social supports (Starcevic & Noyes, 2014). This therapy follows the structure of many other IPT based therapies, and is usually around 16-20 sessions in length (Starcevic & Noyes Jr., 2014). The research base for the effectiveness of IPT for anxiety is growing; however, there is limited research exploring the efficacy of IPT for the treatment of health anxiety.

Chapter Summary

This chapter provided a summary of current theoretical explanations of health anxiety, focusing on the two most dominant: the cognitive model and the interpersonal model. The cognitive model emphasises the significance of bodily sensations and beliefs in the causation and maintenance of health anxiety. In particular, this model suggests the pertinence of the cognitive constructs of intolerance of uncertainty (IU) and anxiety sensitivity (AS) in shaping experiences of health anxiety. The interpersonal model, on the other hand, argues for the significance of early childhood experiences and interpersonal factors in shaping health anxiety. There is limited research demonstrating the efficacy of either of these two treatments. In particular, research demonstrating the efficacy of IPT for health anxiety is in short supply.

CHAPTER 4: COPING

Literature has revealed a number of strategies that are employed by people with high levels of health concern to help them to cope. Although assisting them to cope in the short term, some strategies can increase anxiety in the long term. Insight into coping mechanisms builds understanding surrounding how those with health anxiety function and attempt to manage their concerns and the impacts of these coping mechanisms on their functioning.

Safety Seeking Behaviours

According to the cognitive model, safety seeking behaviours are actions intended to identify perceived threats, avoid them, or endure them when avoidance is not an option (Helbig-Lang & Petermann, 2010). Salkovskis (1996) defined a safety-seeking behaviour as one that is intended to minimise or prevent feared events. These behaviours are pervasive throughout a number of anxiety disorders and prove to be a key maintaining factor for many of them (Powers et al., 2004). Literature from the cognitive perspective proposes that health anxiety has four main types of safety behaviours: avoidance, checking, information seeking, and requests for reassurance (Rachman, 2012). Research has identified some common safety seeking behaviours in health anxiety such as hand washing, excessive reassurance seeking from medical professionals, and examining one's body for 'abnormalities'(Olatunji et al., 2011).

Like other anxiety disorders, safety behaviours prove to be an integral part of maintaining health anxiety. Safety behaviours lead to selective attention on physical sensations and health-related information proving to heighten a health anxious individual's perception of illness risk and reduce their attention to any information

that could disconfirm that perceived risk (Powers et al., 2004). This narrowed view means that health anxious individuals are more aware and hypervigilant of bodily sensations or information than are non-health anxious individuals (Powers et al., 2004). Some safety-seeking behaviours can also serve to increase the symptoms that become misinterpreted, such as constantly checking for lumps, which may in itself create increased somatic symptoms.

The majority of research into safety-seeking behaviours in health anxiety has been quantitatively based. A study by Olatunji et al. (2011) used a quantitative methodology to examine whether safety behaviours exacerbate symptoms of severe health anxiety by randomizing participants into a safety behaviour or control condition. The behaviour control group spent a week engaging in a clinically representative array of common safety behaviours for health anxiety, whilst the control group engaged in their 'normal use' of safety behaviours. The results demonstrated that those in the experimental group reported significantly increased health anxiety compared to those using their normal range of safety behaviours. These results therefore indicate that an increased use of safety behaviours is associated with increases in health anxiety. This finding provides support for the influence of safety behaviours in maintaining health anxiety in this population. However, as this was a quantitative study, the participant's perceptions of why their anxiety increased could not be identified, and this concept proves interesting for further research.

Participants in this study were also primarily Caucasian students, making generalizations across different populations difficult. The findings from this study provide support to study this concept qualitatively, and indicate the potential benefits of using a community based sample to analyse these safety-seeking behaviours across

an understudied population of individuals with non-clinical health anxiety (Olatunji et al., 2011).

Contemporary CBT treatment for anxiety focuses on attempting to get clients to test out the validity of their anxious beliefs by gradually disassembling their safety behaviours (Thwaites & Freeston, 2005). However, recent research has begun to question the efficacy of completely removing these behaviours from the therapy context. Findings indicate that safety behaviours sit on a spectrum, ranging from adaptive coping mechanisms such as focused breathing, to strategies that are less adaptive and designed to prevent catastrophe, such as repeatedly checking one's body for signs of illness (Thwaites & Freeston, 2005). Many people are taught some form of 'adaptive coping strategy' from mental health professionals, such as mindfulness, as tools that they can use to help them to cope with their anxiety (Thwaites & Freeston, 2005).

Thwaites and Freeston (2005) investigated the differences between negative safety-seeking behaviours in panic disorder and social phobia. This study built on the existing literature reflecting a differentiation between adaptive and safety behaviours. They discussed the significance of identifying client's coping behaviours in therapy, and the importance of individual context and motivation of behaviour in order to establish whether this is an adaptive behaviour or a safety-seeking behaviour. This therefore reflects the difficulty of constructing a consistent topology in which these behaviours can be separated and signals the importance of the individual context of these behaviours (Thwaites & Freeston, 2005).

Like Thwaites and Freeston (2005), Rachman et al. (2008) argued that our total rejection of safety behaviours in therapy should be reconsidered. In fact, research

shows that incorporating some judicious safety behaviours particularly at the beginning of treatment can actually be facilitative. Rachman et al. (2008) argued that allowing patients to use safety-behaviours when they begin to feel overwhelmed, particularly in the beginning of treatment, can in fact help to enhance their feelings of confidence and cooperation when engaging in therapy. In line with this proposal, Powers et al. (2004) found that when claustrophobic individuals were able to engage in safety behaviours during in-vivo exposure, there was a marked reduction in their fear levels, which was maintained at follow up. Powers et al. (2004) argued that their findings are likely due to their participant's knowing that the safety behaviours were available if needed, rather than the benefits coming from their actual use.

These findings indicate that distinctions need to be made between safety-seeking behaviours that need to be discontinued and gradually dropped and those that may continue to help the individual (Thwaites & Freeston, 2005). As such, this differentiation within social phobia and panic disorder provides evidence for the potential benefit of analysing types of safety behaviours within the health anxiety context. In particular, the concept of one's 'perception' of their behaviours and its impact on their experience proves useful in differentiating between adaptive coping strategies and safety-seeking behaviours.

Excessive Reassurance Seeking

Excessive reassurance seeking (ERS) is a safety-seeking behaviour often seen in those suffering with obsessive compulsive disorder (OCD) and health anxiety disorder. ERS refers to the behaviour demonstrated by individuals who persistently and excessively seek reassurance from others, be that friends and family or health professionals, as a means to reduce their stress (Halldorsson & Salkovskis, 2017). In

the context of OCD, ERS is perceived as a variation of compulsive checking. This occurs when people with OCD have an inflated sense of their responsibility to prevent harm to others and then become unsure if a threat has been removed or adequately managed (Rachman, 2002). Reassurance seeks to transfer the 'responsibility for preventing harm' to another person by seeking reassurance from them (Rachman, 2002). For those suffering with OCD, ERS is used as a means to achieve a feeling of 'certainty' in the face of a potential threat, often around identifying threats to either themselves or others (Halldorsson & Salkovskis, 2017). However, these checks often create a self-perpetuating cycle of reassurance. Despite an awareness of the influence of ERS in the maintenance of health anxiety, there is little research examining this phenomenon and its function (Halldorsson & Salkovskis, 2017).

Halldorsson and Salkovskis (2017) conducted a qualitative investigation into the difference and similarities in ERS behaviours between health anxiety and OCD. Both groups of participants stated that reassurance seeking was hard to resist, intrusive and time-consuming and noted that they found it difficult to cope when reassurance was not available. For health anxious participants, the main function of reassurance seeking appeared to be drawing the attention of others to their physical state in order for another person to detect any abnormality. Unlike OCD, health anxious participants did not appear to use ERS for emotional support, potentially due to their propensity to believe that their illness fears are rational (Halldorsson & Salkovskis, 2017). For health anxious participants, ideal reassurance involved medical professionals and medical testing, often as a means to reassure them that they are healthy (Halldorsson & Salkovskis, 2017). It was found that all OCD patients found that ERS made them feel better, compared to only half of health anxious patients. This finding may speak to the motivation behind the behaviour of ERS. For

people with OCD this appears to be to share their sense of responsibility with another, and this goal is met when they engage in ERS. However, for health anxious people this is to gain reassurance around their physical condition. In a high proportion of health anxious cases, this reassurance is unable to be provided due to the 'ideal' reassurance for a health anxious person often being from a medical professional (Halldorsson & Salkovskis, 2017).

The Internet

Recent investigations into safety behaviours in health anxiety have centred on the use of the internet as a means to seek reassurance. Muse et al. (2012) investigated a phenomenon referred to as 'Cyberchondria.' Cyberchondria refers to when a person's anxiety about their health is created or exacerbated by using the internet to search for medical information. Muse et al. (2012) explored this phenomenon in a sample of non-clinical student participants, using the Short Health Anxiety Inventory (SHAI) to separate participants into groups based on high or lower health anxiety. This study found that 76% of participants in both the high and low health anxiety groups used the internet as a means to access health related information. However, it was of note that although both groups used the internet to search for health information, those with higher health anxiety were more likely to use the internet to search for health information more frequently and for a longer time period. Their results also demonstrated that participants in the higher health anxiety group reported higher levels of distress when using the internet to search for health-related information. Furthermore, the participants in the high health anxiety group that did not use the internet to search for health-related information reported that this was because it caused them to worry about their health (Muse et al., 2012).

A study by Singh et al. (2016b) investigated health anxious individuals' perspectives on using the internet to investigate health information, and the nature and effects of this usage. Singh et al. (2016b) used a convenience sample of 20 undergraduate students, who scored as highly health anxious (greater than or equal to 18) on the Short Health Anxiety Inventory (SHAI) questionnaire (Salkovskis et al., 2002). A large proportion of their participants stated that a major reason for using the internet for seeking health related information was due to their uncertainty about the possibility and likelihood of having a serious illness. Other reasons included curiosity and remedy-seeking. Individuals used the internet to attempt to alleviate uncertainty due to its speed and convenience. Commonly, participants also used the internet as a preventative method, either in the hopes of preventing a serious future issue or the further deterioration of an existing one. All of the participants used the internet as the first source to investigate their health issues. The study reported both positive and negative outcomes from using the internet for reassurance, indicating that the internet is an important resource to gain health information by health anxious individuals, and has the potential to both reduce and exacerbate their anxiety (Singh et al., 2016b).

It should be noted both Muse et al. (2012) and Singh et al. (2016b) used student samples, focusing on those with high levels of health anxiety. In this sampling we can identify a number of limitations. It seems likely that a student sample are more likely already to have a high rate of internet use and thus would be more likely to engage in internet searching for information. Furthermore, both studies used the SHAI to identify participants with high levels of health anxiety. This fits with a large amount of the research in this area which has focused on the clinical measures of anxiety. Although beneficial, it speaks to a need for research to take place on community samples. In line with this, Easin and Guinsler (2006) investigated the

relationship between online research and health care utilization and internet use, finding that even those with moderate levels of health anxiety seek higher levels of health-related information online (Eastin & Guinsler, 2006). This research therefore highlights a gap in the literature, where those with low to moderate levels of health anxiety also use internet-related safety behaviours, suggesting the potential importance of looking at non-clinical levels of health anxiety, and how the internet is used by them. The influence of the internet on relationships with health professionals will be discussed in the next chapter.

Chapter Summary

This chapter has provided an understanding of the literature surrounding the ways in which people attempt to cope with their health anxiety. It has explored safety seeking behaviours and the influence of these on the maintenance of health anxiety as well as the consideration of these in treatment protocols. It has also provided insight into excessive reassurance seeking, in particular how this impacts health anxiety within the medical setting. This reassurance seeking can often cause health anxious people to engage in a cycle of repeated doctor visits and at times in 'doctor shopping.' The review also explored the emerging significance of the internet on health anxiety. It provided exploration of how the internet can serve to reassure but also to exacerbate health anxiety.

Chapter 5: Health Care Utilization

Primary care physicians are familiar with patients who seek medical help for physical symptoms that appear to have no organic aetiology (Holder-Perkins et al., 2000). Research has demonstrated that these patients engage in significantly higher levels of healthcare utilisation and therefore effective identification and management strategies are essential to reduce burdens to primary healthcare (Barsky et al. 2001). This chapter will explore the presentation of health anxiety in primary care and the way in which it impacts relationships in this setting. It will also explore the postmodern concept of 'healthism' as well as the rise of descriptive psychiatry. Finally, this chapter will outline the present study.

Health Anxiety in Primary Care

A systematic review conducted by Creed and Barsky (2004) estimated that the prevalence of health anxiety in the population to be between 0.02% and 7.77% and between 0.8% to 8.5% in people who attend primary care services. Research has demonstrated that patients with medically unexplained symptoms have higher rates of *medical* outpatient visits, but not significantly higher rates of *mental health* outpatient visits (Barsky et al., 2001). Therefore, these results suggest that patients with these unexplainable medical symptoms are encountered more in primary medical care than they are in mental health outpatient services (Creed & Barsky, 2004). Studies have indicated that the repeated presentation of these patients to primary care settings can often prove frustrating for the practitioners involved, who find themselves repeatedly explaining to patients that what they are presenting with is unlikely to be a physical issue (Barsky et al., 2001). Furthermore, this presentation means that many cases of health anxiety will be missed in medical settings, with only

the more severe cases where there are multiple admissions, and frequent tests, being identified by professionals (Tyrer et al., 2013). Consequently, people suffering from nonclinical levels of health anxiety are unlikely to be identified in these medical settings, and likely largely remain untreated.

Conroy et al. (1999) investigated associations between health anxiety and frequency of general practitioner appointments. They interviewed 200 general practice attenders and found that most of their participants fell into the lowest third of scores in the health anxiety questionnaire, with none of the participants showing pathological levels of health anxiety. Despite this absence of participants' demonstrating pathological levels of health anxiety their results showed an association between health anxiety and self-initiated practitioner visits in the past year. These findings indicate that health anxiety does lead to an increase in practitioner visits. These results are of interest, as these participants sat at the lower end of the health anxiety spectrum but still demonstrated higher rates of practitioner visits, thus demonstrating that even mild levels of health anxiety can pressure primary care services. These findings highlight a deficit in the research stemming from its focus on clinical levels of health anxiety, with clinical levels of health anxiety most commonly being the population studied (Conroy et al., 1999).

Barsky et al. (2001) examined the level of resource utilization by patients with high levels of somatization and health-related anxiety at a teaching hospital. Their results showed that the patients in the top 14% of somatization and hypochondriacal health anxiety had significantly higher levels of utilization of resources, even after accounting for sociodemographic differences and medical morbidity. Their results

therefore indicate that high levels of somatisation often precede high levels of utilisation (Barsky et al., 2001).

Relationships with Health Professionals

As suggested earlier, people suffering with anxiety about their health often do not find long-term reassurance from health professionals or in some cases, do not respond to the reassurance at all (Persing et al., 2000). The importance of the role of the health professional on 'legitimizing' their illness puts pressure on the physician to find an explanation for their symptoms and the appropriate treatment (Barsky et al., 1991). Therefore, this need for reassurance is often combined with a level of hostility which can prove challenging to the relationship (Barsky et al., 1991). Consequently, increased understanding of the patient's perspective of health anxiety and the practitioner's perspective may help to mediate some of the frustrations that often become apparent in these relationships.

Persing et al. (2000) investigated the experience of health anxiety in the medical setting from the patient's perspective. They interviewed 20 patients with DSM-III-R health anxiety and 26 patients without, using a semi-structured interview. Their results indicated that those with health anxiety demonstrated more negative attitudes towards healthcare professionals than those without the diagnosis. The participants with health anxiety expressed feeling that their medical care had not greatly benefitted them and that many of the physicians they crossed paths with seemed uncaring or indifferent to their experience. Their results indicated that in many instances, they experienced poor relationships due to a breakdown in communication and collaboration (Persing et al., 2000). Few of the participants saw this breakdown as stemming from themselves and their often high levels of visits to

clinicians but rather that it was an expected response to the medical illness that they were suffering from (Persing et al., 2000)

An earlier study by Barsky et al. (1991) also examined the views that hypochondriacal patients have of their physicians but also the views that physicians have of these patients. Like Persing et al. (2000), Barsky et al. (1991) also interviewed participants with DSM-II-R hypochondriasis, and then comparison subjects. Barsky et al. (1991) found that hypochondriacal patients were more dissatisfied with their clinicians than comparison patients. In turn, the physicians rated hypochondriacal patients as more frustrating to care for, more help-rejecting and more demanding than comparison subjects. These studies provide a valuable insight into what can prove to be a frustrating dynamic. Research suggests that physicians often find hypochondriacal patients hard to deal with and hypochondriacal patients do not feel heard by their clinicians. Consequently, the relationship between healthcare providers and hypochondriacal patients can often prove strained, despite the often critical aspect of this relationship in the hypochondriacal experience.

Research has suggested the significant influence of the internet on damaging relationships with health professionals for those suffering with health anxiety. Studies show that patients often use the internet as a means to prepare for their consultation with their doctor, and that many bring the information with them to their appointment. In most cases this behaviour can assist in speeding up consultations, and often the information available on the internet means that the person will not go to the doctors at all. Consequently, the internet can help to reduce burdens on health services. However, the 2013 Pew Internet and American Life Project reported that when people do seek consultation with their doctor in approximately one out of five instances, the

patient's self-diagnosis and the doctor's diagnosis were discordant (Fox & Duggan, 2013) . Therefore, patient's satisfaction with the outcome of the consultation is likely to be affected, patients are likely to feel less understood and to hold doubts around the doctor's diagnosis, or perhaps just even more confused by the contradictory information (Fox & Duggan, 2013).

Tanis et al. (2016) investigated the influence of online information searching on satisfaction with medical consultations, specifically looking at the role of health anxiety within this context. Their results showed a positive relationship between health anxiety and online health information seeking and also indicated that health anxious people are less satisfied with doctor consultation. People searching more extensively for health information online appreciated their consultation less but only if they were health anxious (Tanis et al., 2016) These results fall in line with Bylund et al. (2010), who investigated the impact of internet information on communication between doctors and patients for a sample of cancer patients. Their results demonstrated that when doctors showed interest in the internet information and took it seriously, patients were less likely to want to change the doctor's response (Bylund et al., 2010).

These studies show that the internet has significantly altered the way that we access and attend to health information, but also the way in which we interact with health professionals, and the quality of relationships in this context, particularly for those that are health anxious. This research speaks to the need for patients to understand that their diagnosis may not align with the doctors, and the need for doctors to make consultations feel more collaborative to patients and to take into

account and validate health related information that the patient has found. This is particularly important for those with health anxiety.

Healthism

Health consciousness is embedded in affluent, Western society. Individuals are expected to take measures to protect and maximize their health for the present and for the future (Ayo, 2012). The neoliberal movement of 'healthism' has removed the responsibility from health away from the state to the individual who is expected to strive for health and wellbeing (Ayo, 2012). Robert Crawford, a political economist, argued that being health conscious today is having the understanding that one's health is in "continuous jeopardy" (Crawford, 2006, p.403). He described behaviours as being defined as either healthy or unhealthy. It is practically impossible to function in modern society without being bombarded with health-related information, fuelled by a continually growing consumer empire of health-related advice, products and initiatives. We can see the continuing growth of the individualization of health in areas such as the development of genetic technologies, medical monitoring and workplace initiatives (Crawford, 2006)/

One of the most prominent examples of this policy change can be observed in the increasing number of health checks offered. Health checks aim to identify risk factors for a disease. Common examples of these include cervical smears and prostate checks. Stol et al. (2016) researchers on medical ethics, have argued for the influence of health checks on the pressure behind the individual to be responsible for their own health. They argued that health checks convey the message that the health checks mean that disease is preventable, or at least preventable from getting worse (Stol et al., 2016). Therefore it seems feasible that if one did not attend a screening and

became ill, there could be a sense of guilt attached to this, or a sense that there was more you could have done to 'protect' yourself. The focus of these policies on individual responsibility to check their health arguably means that health anxieties are necessary to encourage individuals to check their health, and to work to align their behaviour in line with social constructions of what is considered healthy behaviour (Crawford, 2006).

The Present Study

The present study explored the experiences of people who self-identify as 'excessively' worrying about their health. For the present study, this was conceptualised as when participants themselves believed their worry to be excessive.

There were a small number of studies that have qualitatively explored the experience of health anxiety (Beckett, 2009; Singh et al., 2016; Singh & Brown, 2016a; Singh & Brown, 2016b). All of these studies have focused on specific components of experience such as the internet, relationships with medical professionals and links with other psychiatric disorders. The present study aims to explore this experience from the ground-up, letting participants identify factors that they deemed relevant to their experience as a means to better understand the concept of health anxiety, its construction and the ways in which people interact with it. Further exploration of this phenomenon will serve deepen understanding and better inform intervention.

CHAPTER 6: METHODOLOGY

Rationale

As discussed in the literature review, experiences of health anxiety are relatively common within the population, but often present to medical rather than mental health settings. These patients can place a significant burden on healthcare resources and can prove difficult and frustrating for medical professionals. When it does present, health anxiety is hard to identify, making it likely that those who have subclinical levels of health anxiety are often missed in medical settings. As much of the research in this field has used clinical measures, this study used a community sample to respond to literature demonstrating the high levels of health anxiety in the community, and the uncertainty surrounding the clinical picture of health anxiety as discussed in the literature review. Better understanding of how health anxiety is experienced will help to improve the identification and management of health anxiety.

The present research used a qualitative design to explore the lived experience of people who worry to 'excess' about their health. In this case, 'excess' was deemed to be when participant's judged their worrying to be impacting on their functioning. A qualitative design was employed in response to the scarcity of qualitative research in this field because it offers the opportunity to capture the nuances and complexities of individual experience.

Theoretical Underpinning

The present study will explore and analyse these experiences through a social constructionist paradigm. The social constructionist paradigm argues that knowledge and truth are constructed through interactions within a social context (Teater, 2015). Social constructionism emerged in the 1960s and finds its origins in sociology (Conrad & Barker, 2010). It argues that reality is relative to individuals and the particular context they find

themselves in. Therefore, this theory rejects positivist notions of an objective 'reality' from which we can obtain impartial knowledge (Lincoln et al., 2016). According to social constructionism, knowledge is not discoverable but rather is created by exchanges and interactions between our social and biological processes (Lincoln et al., 2016). As such, in this study it is implied that participants create their reality within the bounds of their social and cultural context and under the influence of the prevailing belief systems of their particular social and cultural context (Rapmund & Moore, 2000). According to this paradigm, when psychology adopts a scientific discourse it gives the researcher a greater claim to knowledge than their participants (Burr, 2015). Social constructionists advocate for the process of collaboration in research, where the research process is informed by the participants (Gergen, 2001). In line with this, qualitative studies often provide the ideal context for preventing participant's accounts being decontextualized, keeping them embedded within their social context (Burr, 2015).

Social constructionism provided the research paradigm that best supported the intentions of this study, one strongly focused on personal experience and the context in which participant's meaning making takes place. This social constructionist epistemology was chosen as a result of the changing understandings of what it means to be health anxious, as shown in the shifting diagnostic criteria as well as the high levels of missed diagnoses. Both of these factors therefore suggest limitations in the understanding of this phenomena and how it is experienced by sufferers. This analysis was intended to help to expand theory surrounding thoughts and behaviours in this area, as well as to see how these fit with the current theoretical understandings. A qualitative approach allowed the research to gain a sense of the participant's holistic experience, taking into account the influence of their social contexts in constructing their reality. The need for a social constructionist approach became apparent when exploring contemporary understandings of health anxiety and the significance of social context in factors

such as safety-seeking behaviours and early trauma in crafting health anxiety. Consequently, it became evident that the social context would be impossible to separate from the experience of health anxiety.

In social constructionism, meaning making in research is a co-constructed experience. The researcher can have the theoretical knowledge of health anxiety but the participant holds the power of their lived experience of it. By keeping this tension explicit, the power dynamic becomes more equalised (Stumpers, 2012). In line with this, the research question was not constructed by the researcher, but rather was constructed through the research itself. The social constructionist paradigm meant that particular attention in analysis was paid to the historical and cultural influences on participants' experiences of health anxiety, as demonstrated through increased focus on areas such as relationships and experiences with health professionals.

Social Constructionism and Illness

The bio-medical model of illness and its associated diagnostic language constructs a sense of 'truth', regulating normality and abnormality and defining what is perceived to be acceptable in terms of health (Wagner & Von Korff, 1996). Medical sociologists have challenged this traditional positivist framework, instead arguing that illness is shaped by its social and cultural context. In this framework, illness as we perceive it does not exist independently of our social reality (Wagner & Von Korff, 1996). Within this structure, it is therefore posited that illness is the product of medical discourses (Turner, 2007).

Society has a tendency to encourage medical solutions whilst being discounting of the social context in which these conditions occur (Conrad & Barker, 2010). Of course, mental illness has a biological component to it. However, this ignores other features, labelling people as ill without taking into account the social context on which their symptoms have been established (McCann, 2016). When examining anxiety from this perspective, social and

historical context is important. Ian Dowbiggin (2009), a professor of history, explored the role of social constructionism in anxiety. He discussed heightening levels of anxiety apparent in the twenty-first century. He argued against traditional arguments that this increase was due to the pressures of modern life, instead discussing the significance of the contemporary social ethos that places anxiety as an acceptable emotion response. He noted the importance of the historical context to our understandings of anxiety, commenting that in the nineteenth century, anxiety in women was often seen as a positive attribute, one that made them more modest. He also discusses the significance of the rise of medication, meaning that anxiety too could be treated just like any other disease (Dowbiggin, 2009). So, we can see the importance of social and historical factors in shaping our understandings around anxiety, and in turn its relevance to policies and treatment.

Without societal influence, conditions would not be stigmatized Rather, stigmatization is a manifestation of the social response to certain conditions (Conrad & Barker, 2010). Research has examined the social construction of illness where the sufferer claims to have a disease without any known physical abnormality, such as fibromyalgia or chronic fatigue. In these cases, the fact that their symptoms are not associated with a known medical illness can cause significant negative implications to their ability to access care and funding and often they experience suspicions that their problems are psychological (Conrad & Barker, 2010). The aim of research constructed within this framework is to understand how participants experience are constructed, relying on their narratives whilst acknowledging that these are often negotiated socially and culturally (Stumpers, 2012).

The Role of the Researcher

When working within a social constructionist framework, the researcher should acknowledge their active involvement in the process of discovering meaning and

understanding (Kim, 2006). Through this process, the researcher does not have to decide whether the participant's narrative reflects either a true or false reality, but rather it is assumed that reality is subjective to the experiences and social and cultural background of that person (Rapmund & Moore, 2000). In line with this, the researcher's own social and cultural context should also be taken into account when sharing the narrative of the research findings (Rapmund & Moore, 2000). Social constructionism also acknowledges the importance of the interaction between the researcher and participants in the construction of knowledge, where both possess insights that when shared in interaction may shape a constructed knowledge (Rapmund & Moore, 2000).

Reflexive Note: In acknowledging the researcher's role in co-constructing knowledge with the participants, reflexivity proved crucial to this study. I remained aware that it is impossible to have a completely objective qualitative research. The choice of the research itself even reflects bias, as I chose this topic due to my own interests in this phenomenon. As such, I worked to remain self-aware throughout the process. For me this was done in two key ways: The first of these was to engage in reflective journaling after participant interviews and supervision sessions, providing me with a sense of reflection as the research progressed. I also made use of supervision as a space to challenge and reflect on my own personal biases, particularly those that I felt might have been impacting my lines of questioning. For example, attempting to make comparisons in my interviews to obsessive compulsive disorder.

I needed to be aware of any personal biases that also may have arisen because of my own upbringing. I have family members who suffer from Obsessive Compulsive Disorder, and it was of note that many of the experiences shared by the participants reflected those often experienced by those with OCD. Therefore, I needed to be mindful of my own transference

when interviewing participants and potentially imposing theory and my own experiences with OCD on participants' accounts.

I come from a long line of medical professionals, and needed to be aware of this particularly in discussions related to the practice of medical professionals and the influence that these experiences had on participants. It is also of note that I looked at a substantial amount of literature from the health anxiety field prior to commencing my research.

Furthermore, as a training clinical psychologist, I had to be mindful that it was not my place to attempt to 'fix' or support these participants in their difficulties. At times this was challenging. Occasionally I had to assume a caring and supportive role to ensure the safety and well-being of the participant, whilst making sure that I remained outside of the therapeutic space to them. Sometimes this was difficult and the balance between therapist and researcher could appear blurred.

Health anxiety has always been of interest to me, potentially due to my upbringing entrenched in the medical world or its overlaps with OCD. My psychological training outlined the significant gaps in our understandings of this disorder and thus appeared to provide little insight in to how this phenomenon presents. I also remain consciously aware of the influence of the media in constructing our narratives of health, and how this may be influencing the presentation of health anxiety. As such, this project intended to: 1) better understanding the lived experience of health anxiety. It attempted to avoid the imposition of diagnostic categories in the hope to allow participants to articulate their experience in a rich manner rather than being curtailed by expert frameworks; 2) to explore how this community may be better supported; 3) to explore whether the theory and disorders accurately reflect the experience of these clients; and 4) to explore the way these qualitative accounts both challenge and confirm the existing frameworks of this phenomenon.

As this project progressed, I became increasingly aware of my propensity to lead questioning towards traditional models that I had come to know through my training. At times I felt that I failed to explore experience at a deeper level, instead taking what the client said at face value, and placing it into my preconceived notions of their experience. As such, after the first three interviews, I reflected as I listened to my interviews and read through my transcripts. I returned to my question guidelines and reshaped them in a way that was more consistent with the experiences that had been described to me so far, rather than simply reflecting and affirming past theory. This experience reflects what is likely happening to people struggling with these difficulties in the therapeutic and medical settings where they often feel silenced or invalidated by similar processes, with their experience seen only through the lens of 'expert' knowledge.

Although I worked to be more aware of my own biases here, it would have been unrealistic for me to expect that this research could be done with no biases at all. As stated by Berger (2015), reflexivity challenges the view that knowledge is independent of the researcher. What it meant was being engaged with the client in the present moment, and shaping questions based on their narrative rather than the line of questioning I had already mentally established.

Participant Inclusion Criteria

The criteria for inclusion in the study was that participants be aged 18 years and above, who self-identify as having excessive concerns about their health. Participants were not required to have a diagnosis of Health Anxiety Disorder as outlined in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed,; DSM-5; American Psychiatric Association, 2013), and participants were not screened for this. As indicated in the literature review, there is a noticeable absence of research that does not use clinical criteria. As demonstrated in the statistics of health anxiety in the population, there is a need to incorporate those who may not

fit clinical criteria, but whose functioning may be impacted by their health anxiety. As such, this study attempted to obtain a better understanding of the concept of health anxiety in general, by analysing health anxiety experienced as excessive by the participants themselves rather than through external measures and criteria.

Participants were recruited from the community through a number of methods, including flyers on community notice boards, flyers on university noticeboards, recruitment through doctor's surgeries and posts on Facebook groups for anxiety support as well as local community Facebook groups. 'Snowballing' was also used through posts on Facebook, which were shared by friends and one Doctor's surgery who shared it on their public Facebook page. The flyer included a small amount of information about the study, as well as a contact email set up specifically for the study which potential participants could contact for further information.

Participant Exclusion Criteria

Participants were excluded if they had an unstable or life-threatening medical or neurological disorder, had a current or lifetime diagnostic of psychotic symptoms or a current high risk of suicide. This information was outlined in an information sheet provided to the participant prior to the interview and as such was subject to their own self-report. However, participants were encouraged to contact the researcher should they have any queries about fitting the criteria. When participants had concerns about fitting criteria, the researcher discussed these with supervisors. The exclusion criteria of having an unstable or life-threatening medical or neurological disorder proved challenging in a couple of cases, as some participants did present with chronic medical issues. However, these concerns were discussed with the research supervisors after further information was gained from the participant. In this study, there were no participants that self-reported criteria that would have excluded them from

the study. If it had been the case, this would have communicated to them via email and a list of relevant support resources would have been provided. Participants were also provided with resources at the end of the interview for extra support should they need it. No participants reported risk to self during the study. Participants were also excluded if they were too medically unwell or distressed to attend the interview, as there were concerns of further aggravating any medical or distressing symptoms through the content or experience of the interview. Two participants did not participate in the study after reading the information form and self-reporting that their health issues excluded them from the study.

Participants

At the beginning of the study Malterud's (2010) factors regarding *information power* were considered. Malterud (2010) discussed the importance of considering factors such as breadth of the study aim and the quality of the dialogue provided in interviews when attempting to calculate the number of participants. The broadness of the topic suggested that a larger sample may be needed. However, this was balanced with acknowledgment that this was a time-limited research project and too much information could prove difficult to analyse and to organise. Moreover, it was important to be mindful of maintaining the richness of the information provided by the participants which arguably could become more difficult to do with a greater sample size (Malterud et al., 2016). It became apparent that after three participants, the data was already rich. This perhaps resulted of the interviewer's training as a clinical psychologist, and the experience of her supervisors as practicing psychologists, as well as the strength in articulation of the participants involved. As such, it was acknowledged that due to the richness of data, a lower number of participants would likely be needed. It became evident at around seven participants that numerous themes were reoccurring, and as such it was recognised that recruitment would cease shortly after. After reviewing transcripts, it was

decided that enough data had been collected to provide a comprehensive analysis. As such, after nine interviews recruitment ceased.

Participants ranged in age from 27-75 and were all female aside from one male (see table). Participants had an average age of 41 (SD:20.86). All participants were given a pseudonym to provide privacy and confidentiality. The sample consisted of four participants who identified as NZ European, three who identified as Asian, one as South American and one as European.

Table 3.

Participant demographics

Pseudonym	Age	Gender	Ethnicity
Claire	27	F	Asian
Diane	54	F	NZ European
Sarah	24	F	NZ European
Courtney	18	F	South American
Joanna	38	F	European
Kim	52	F	Asian
Paul	75	M	NZ European
Emma	18	F	Asian
Lisa	63	F	NZ European
	Mean: 41		
	SD:20.86		

Interview

At the beginning of the interview, participants were asked to complete a demographic questionnaire (see appendix). This questionnaire asked participants to identify their age, sex, marital status, ethnicity, employment and educational background.

Semi-structured interviews were used to allow for flexibility in participant experience, to allow them to share their experiences outside of strict interview protocol, in line with the inductive methodology of this study. The length of interviews ranged from around 50 minutes to 90 minutes. At the beginning of interviews, a loose template of questions needed to be established. As emphasised by Creswell (2007), qualitative questions are evolving. The initial interview guideline that was initially designed was reconsidered in supervision prior to the commencement of interviews. This initial guideline was built around the five part model, and as such, conflicted with the inductive nature of the study. Interviews within a social constructionist framework present the interview as a place of meaning-making between individuals, facilitated by knowledge exchanges, where the interviewer and the participant both assume the role of researcher and construct knowledge together (Holstein & Gubrium, 2008). The social constructionist framework emphasises process rather than structure, and is understood as a product of linguistic, cultural and historical context. As such, initial enquiries sought to investigate their understandings of health, and their experience with communicating in relationships, in both the domestic and professional settings.

In line with the constructionist framework, the content of the interview was seen as dynamic, where the focus could and likely would be shifted during and following interviews (Holstein & Gubrium, 2008). After the first three interviews, the questioning template was redeveloped in order to be responsive to data that had been obtained and the topics that participants viewed as pertinent to their experience. It was apparent that these initial questions

were too individualistic in nature and needed to explore the influence of social and historical factors more deeply. In particular it became apparent that participants had placed help seeking experiences as significant to them and in line with the social constructionist framework, focusing more on this area appeared pertinent to the research question.

The final research questions focused on these topics:

- Content: What do you worry about?
- Consequence: How does this worry impact your functioning?
- Coping: How do you cope?
- Help seeking experiences
- Hopes for the future

Transcribing after every interview allowed time for reflection and consolidation of understanding, as well as for consideration of the line of questioning. In line with the social constructionist framework for this study, I was sensitized to the influence of relationships on experiences of health anxiety. For participating in the study, participants were given a $20 fuel voucher.

Ethics

The research proposal was peer reviewed by two psychologists and evaluated to be low risk. The Code of Ethical Conduct for Research, Teaching and Evaluation Involving Human Participants (Massey University, 2015) provided the basis for this discussion. A number of key considerations were identified:

A. **Risk of harm to self or others** In order to help mitigate risk of including those at high risk of harm to self, a high risk of current suicidality was an exclusion criterion for this study. However, this measure in itself is not entirely protective against interviewing

participants with a high level of risk. Prior to commencing interview, participants were informed that if they raised risk of harm to self or others, relevant agencies would be informed. If they did raise risk of harm the level of risk would be assessed in semi-structured interview using a screen and clinical judgment. All participants were provided with a list of agencies and corresponding contact details that could provide them with psychological support. Following completion of the interview, participants were encouraged to seek additional support should they view this as necessary. In response to the possibility that someone could become distressed in the interview, or present with risk, the project's initial supervisors, two practicing clinical psychologists remained available for consultation with participants in a private, confidential setting should this be needed. It was also made clear to participants prior to their interview that the purpose of the interview was not as a treatment session, but rather an exploration of their experience.

B. **Confidentiality** Participant's names will remain confidential with only the researcher having access to them. They would be given a pseudonym in the final research project, and confidential documents and recordings would be securely stored.

C. **Cultural Safety** In terms of cultural safety, a Maori cultural advisor was consulted prior to the commencement of the study. This advisor provided direction regarding interviewing participants experiencing these difficulties and offered to provide ongoing cultural support. For non-Maori participants, discussions were had with supervisors around relevant cultural issues that needed to be considered prior to interview and when analysing data.

Analytic Procedure

The six stages for thematic analysis as suggested by Braun and Clarke (2006) were used (see appendix F). The first stage of this is to become familiar with the data. This involved reading and re-reading the transcripts and searching for patterns and meanings across them. The vast quantity of data made this stage overwhelming. This was heightened by the lack of specificity surrounding research questions, in line with the inductive methodology of this study.

The second phase involved making initial codes of the data, working to organize the data into meaningful groups. This coding was largely data-driven as this study is an inductive analysis. Around 50 initial codes were established across the data sets. Coding was through assigning extracts of data code with a temporary title, and extracts that appeared to fit under this code were grouped together.

The third stage involved attempting to sort the codes into relevant themes and subthemes. Codes were combined into meaningful groups, and placed under one or more themes, or a miscellaneous category if it did not appear to fit well with the themes already found. For example, a code of 'comorbid mental health' was established, with a number of quotations appearing to fit within this. However, when reviewing this, it became apparent that in coding using this language, diagnostic framework was being used to conceptualise their experience. Instead, many of the extracts coded under this were recoded under the theme of labelling, to allow for their own experiences of feeling labelled by this to drive the analysis. These themes were then organized into various subthemes in order to break down the significant components of each theme.

The fourth phase involved reviewing these themes. The themes for this data set were altered and edited numerous times, in order to find the most cohesive and clear way to explain the data. This was a difficult and arguably the most time-consuming of all of the phases of

analysis. It became apparent that there was a significant amount of overlap in these themes and subthemes, particularly those regarding relationships with health professionals. As such, this difficulty was acknowledged and the current presentation of the themes was decided on. It was also evident that the themes at first were broad, one of them being 'content', this was intended to identify the content of their worries, but it was found that in fact content of worries was dispersed across all the themes.

CHAPTER 7: FINDINGS

The aim of this chapter is to present an analysis of the findings of the interviews with the nine participants. After reading and re-reading the transcripts a number of times, six themes emerged that appeared to capture the experiences of the nine participants most effectively (see Table 3). Presented in this chapter are the six themes that emerged from the interviews. These themes are: *Relationships, Invalidation, Insight, Better Safe than Sorry, Vulnerability* and *Therapy*. Each of these six themes have a number of subthemes attached. The subthemes are intended to construct more specified discussions around aspects of the theme. In the discussion of the findings below extracts of text from the participants are explored and discussed in relation to the relevant literature. The themes and subthemes as well as a short description of them are provided in the table below. These themes are also presented in the map below (Figure 2).

Figure 2.

Map of Core Themes and Subthemes

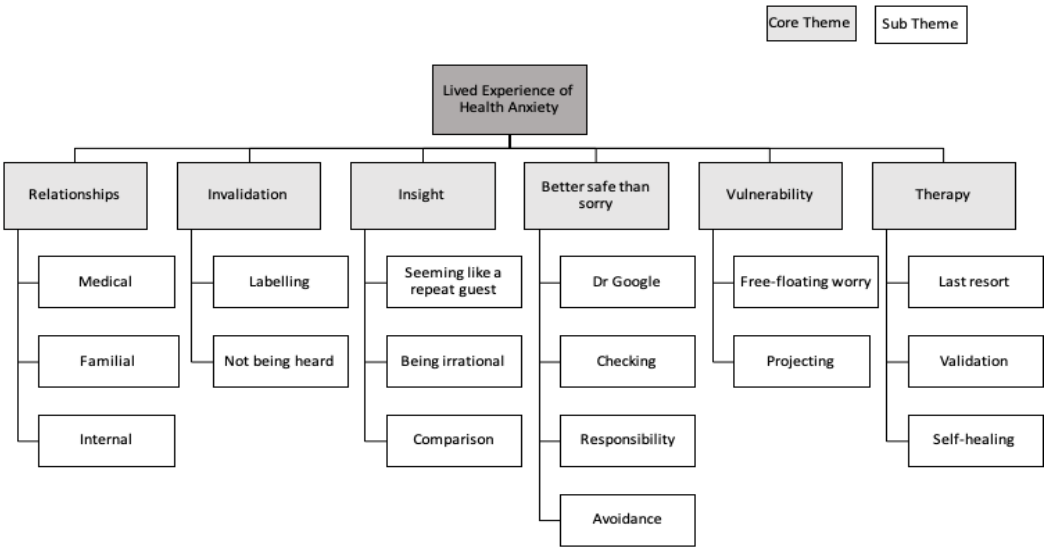


Table 4.

Breakdown of Themes and Subthemes

Theme	*Subthemes*	*Description*
Relationships	Medical	Explores participant's significant relationships
	Familial	
	Internal	
Invalidation	Labelling	Experiences of feeling invalidated when seeking
	Not being heard	support.
Insight	Seeming like a repeat guest	Explores participants' awareness of their own
	Being irrational	behaviour and cognitions
	Comparison	
Better Safe	Dr Google	Explore's participant's attempts to manage their
than Sorry	Checking	anxiety.
	Responsibility	
	Avoidance	
Vulnerability	Free floating worry	Explores participants' sense that their bodies are
	Projecting	vulnerable, not only now but also in the future.
Therapy	Last resort	Explores participants' experiences with mental
	Validation	health services, therapy and their own personal
	Self-healing	journeys to find comfort and healing.

Theme 1: Relationships

The majority of the participants described an experience with illness which was influenced by the relationships in which they were engaged. This theme is split into three subthemes of 'medical', 'familial' and 'internal.' The first theme, 'medical', was concerned with the role of health professionals in their illness experience; the second theme, 'familial', explores the influence of family and, third, the theme 'internal', refers to their relationship with their own bodies.

Medical

For all three of the participants who described a negative experience with their own health, this event happened in adulthood. These participants attributed their illness worry to a medical procedure that had 'gone wrong.' All three of these participants recounted medical procedures or interventions that were relatively routine but described consequences that were unusual and unexpected. Many participants spoke of the influence of medical professionals on their experience and the lasting impact that this had on their ongoing perceptions of medical professionals and their interactions with medical services.

Two of the participants recalled a traumatic experience with a somewhat routine medical procedure.

> *I had what was meant to be a very straightforward procedure for my tooth, instead it ended up being like an hour and a half long, they chucked a bone graft in cause there was a piece of bone gone from my mouth or something. I always feel like that was the point when my health*

anxiety came in, I ended up having a really bad infection after surgery, they threw me across like four hospitals because no one knew what was wrong (Claire, 27)

For Claire, this difficult medical experience was the beginning of her journey with health anxiety. In the extract above, she uses dismissive language when relaying her experiences. Her use of the word "chucked" reflects an experienced lack of care towards her by her dentist. Her description of being "thrown across" different hospitals, is reflective of a sense of feeling disregarded, as well as a belief that professionals did not know how to care for her. For Claire, the difficulties that she experienced then continue to influence her expectations and perceptions of medical professionals.

Joanna, 38, also experienced a traumatic experience with her own health, when she was temporarily paralysed following an epidural.

INT = Right so the epidural para…

Joanna = hit a nerve and paralysed me

INT = Oh wow ok, paralysed you?

Joanna = Completely paralysed me, it left a haematoma on my spine which I had to have dexamethasone to like…dissipate or whatever it does and but obviously because it's your spinal cord the effects of that are still quite ongoing.

Similar to Claire, Joanna had what is usually considered to be a 'routine' procedure from which she experienced unexpected consequences. Following this procedure, Joanna experienced paralysis for five days and was hospitalised for a

month. The impact of this 'routine' procedure made it so that she was unable to care for her newborn. Joanna described ongoing difficulties from this, describing issues in relation to her bowels and bladder and lower limb weakness which make daily functioning extremely challenging. Joanna's ongoing difficulties mean that she is constantly reminded of the trauma associated with this experience. For her, this experience has permanently affected her relationships with health professionals.

> *Joanna = but yeah a lot of anxiety around that…um but that's kind of spilled into anxiety around like around trusting people and stuff like that you know um…really hard time trusting anybody from ACC, quite a hard time trusting medical staff, any procedure they wanna do I'm like well why, what are my options, no I don't want that done or um…yeah so yeah that's been*
>
> *INT = Makes sense right yeah*
>
> *Joanna = Yeah because ultimately it's the hospital that did it to me so…*

As a result of her prior trauma a level of trust towards medical professionals was lost. This fractured trust also extends to other related organisations such as the ACC. Research has shown that people who experience traumatic medical events are often averse to future medical procedures, as well as stimuli associated with medicine (Shalev et al., 1993). A recent study by Ottosen et al. (2018) in the US explored the experience of participants five years after a traumatic healthcare event. This study identified that 31% of participants had altered their healthcare seeking behaviours following their traumatic experience. Many reported that they refused to seek future care in hospital as a result of the harmful event and their experiences of inadequate communication by the personnel there. Some reported an increased likelihood to seek

a second opinion or to research healthcare information on their own, whilst 50% of the patients reported anger and frustration towards healthcare professionals and their associated bodies (Ottosen et al., 2018). This fits with Joanna's experiences of altering her behaviour towards medical services, as well her sense of frustration. As such, this research and the difficulties experienced by both Joanna and Claire speak to the need for better understanding of the long-term implications of medical trauma and for an increase in longer-term support for such patients.

Joanna wants to have more autonomy over her own body, clearly separating what "they wanna do" from her "options" and having the autonomy to say "no I don't want that done." For her, it is important that she re-establishes a sense of control over her body. Many of the participants described a sense of urgency towards regaining control and autonomy over their bodies. This is an idea explored in more depth in Theme 4, 'Better Safe than Sorry.' Joanna's experience raises the issue of the power of doctors and its normalisation in society. Society perceives doctors as the owners of medical knowledge who we should trust with our bodies, giving them ultimate control over decisions made around them (Yan, 2018). However, when Joanna's trust in medical professionals was fractured, she begins questioning this power dynamic and the idea that doctors 'know best.' This tension was also present in the interview with Diane, 54.

> *I had very, very mild anxiety prior to six months ago, and it was mostly if I didn't know where I was going if I was driving somewhere. So I spoke to my Doctor and she suggested putting me on Escitalopram which is an anti-depressant… put me on that low dose because I tend to have, I'm quite sensitive to medication we knew that. Put me on half the*

recommended dose initially so it was only 5mg…um…six weeks later…I had, I woke up one morning with the most god awful adrenaline surges from my torso up to my neck out to my arms, they were absolutely horrendous they were almost, I was just incapacitated. (Diane)

Oh and I even think the doctor should not have prescribed it to me now, yeah…it should have, even her advice should have been well its only mild lets look at some other avenues before we go down this path (Diane)

Like Claire and Joanna, Diane also experienced unexpected consequences from something considered routine within the medical field and as a result experienced a lack of trust towards health professionals. Research indicates that trust is a critical factor in influencing doctor/patient interactions (Brennan et al., 2013). Anthropologist Yunxiang Yan (2018) argued that the doctor/patient relationship is hierarchical by nature, with the power dynamic dictated by knowledge, information and access to resources(Yan, 2018). Research by Yan found that in most cases this trust is undermined when something goes wrong in the treatment process, leaving the patient with a sense of betrayal. In line with this, Brennan et al. (2013) found that this level of trust influences factors in the relationship such as the patient's likelihood to engage with therapeutic recommendations, their satisfaction with their physicians and improvement in their symptoms. In the narratives above, something going wrong in the treatment has undermined the participants' trust in physicians, altering this power dynamic. Consequently, these participants have begun to question the knowledge of their physicians, their reliability and have worked to increase their own power in these relationships.

Attitudes towards medical professionals described in this study were largely negative. This finding supports other research on the doctor/patient relationship which indicates that people with health anxiety report more dissatisfaction with their medical care and make significantly more negative comments about their physicians (Barsky et al., 1991; Persing et al., 2000). Persing et al. (2000) found that patients with health anxiety made significantly more negative comments about their physicians, often viewing them as unskilled and uncaring, and spoke of the influence of poor communication on their negative experiences. Similar to the participants in this study, Persing et al. (2000) found that much of their participant's distress was focused on physician-patient relationships that they felt had failed them (Persing et al., 2000). As such, we can see the significance of this relationship on the experiences of health anxiety, and the importance of collaboration in helping to shape a trusting therapeutic alliance.

In line with findings by Persing et al. (2000), it is suggested that to establish this alliance, the health professional must communicate the legitimacy of their help seeking, and help to explain that the goal may not be to remove symptoms, but to help them to cope with them. It is anticipated that this would help to alleviate frustrations for both doctor and patient (Persing et al., 2000). Interpersonal interactions have received far less attention in the literature surrounding health anxiety. However, as evidenced by its significance to our participants, greater understanding of these interactions could lead to improved treatment outcomes (Williams et al., 2010).

Familial

A number of the participants reported vicarious experiences of medical event(s) within their family. Lisa, 63, discussed her mother's diagnosis and eventual decline from Parkinson's dementia.

> *I think it was my mother's thing that like struck me so…it as like such a…it was such a big diagnosis, it was such like a "how the fuck did this happen" you know, I just couldn't, I think I still can't quite you know (Lisa)*

Lisa's use of the word "struck" relays the shock and the significant impact that her mother's diagnosis has on her. Although she reported that her mother's illness was the most likely trigger or her anxiety, her health concerns were not specific to dementia.

> *I don't think anybody knows more about your body than you, but of course it's a paradox because there's so many stories of people that you know there's something wrong with them and they have no clue and I never know whether I would be intuitive enough to know (Lisa)*

Lisa's narrative speaks to the idea of the unexpected, reflecting her feelings surrounding the vulnerability of her physical body and the perceived ineffectiveness of her own intuition around their bodily health. For Lisa, her mother's illness crafted a sense of unease in her ability to recognise illness in her own body, as neither her mother nor she recognised illness in her mother's body. Disease therefore is seen as insidious, requiring heightened levels of surveillance. There is a general feeling of shock and trauma, where participants felt overwhelmed by their experiences.

However, this feeling does not appear to be mediated by health professionals, with none of the participants reporting any support after their initial health trauma.

Emma, 18, has two parents who had both experienced significant illnesses. She described her mother's illness as particularly difficult for her.

> *I was really young yeah, and it definitely had a major toll on me, cause I mean my mum's the love of my life and when I heard that she got sick oh I was so upset um…I went through a phase of depression (Emma)*

> *…My mum just recently had a UTI and I was out when she told me, and she was freaking out, and I was freaking out and I was with my partner at the time and I just cried cause I thought, and we had to go to the hospital cause we had no idea what was going on, and it just dawned on me that could happen (Emma)*

Similar to Lisa, Emma's experience with her mother's illness demonstrated to her the vulnerability of the body, where illness "could happen" to either or her mother, or to her. Her mother also shares the same concern "freaking out" when told she had a urinary tract infection.

Like Emma, Sarah, 24, also discussed her mother's anxiety around health and its influence.

> *Um I have a sneaking suspicion that it's because, for starters, my family has a strong band of depression and anxiety based things coming through it, and my mother was a nurse, and when she stopped nursing, she still kept the house nursing clean and she had, and when she stopped being able to keep it nursing clean because she had three children, then she*

imposed like rules on us for how to do it, because basically she had, for most of my childhood very poorly managed Obsessive Compulsive Disorder or at times completely unmanaged so it was stuff like we wouldn't be allowed to touch taps, or certain parts of the towels when you were drying your hands, doorknobs or anything because they had, they were dirty and if you touched the dirty thing that was bad, and you always had to wash your hands if you went to the bathroom, which obviously everyone does, but she would get militant about making sure you did and stuff like that… (Sarah)

…I'm not, I wouldn't say I'm like a dirty person, I'm a very messy person but I don't like things that I think are dirty and they have to go into certain places, they have to have their spot like all of my dirty laundry has to go into the laundry spot, and it doesn't matter if the laundry pile is really big it has to stay in that place…(Sarah)

Emma's narrative has some evident similarities with that of obsessive compulsive disorder (OCD). She relays her mother's difficulties with OCD and the influence that this has had for her. Research reveals an overlap between OCD and health anxiety, demonstrating similarities in elements such as obsessional thoughts around illness and contamination, intolerance of uncertainty, somatic focus and reassurance seeking (Deacon & Abramowitz, 2008)

Despite these participants' discussion of the significance of familial experiences on their health anxiety, the research on the origins of health anxiety is still far from certain (Hadjistavropoulos et al., 2014). However, the majority of the research in this area indicates that the likelihood of developing health anxiety as an

adult is partly shaped by illness experience as a child (Hadjistavropoulos et al., 2014). According to the cognitive model, dysfunctional beliefs around illness are often shaped through the individual's early experiences with illness, be that their own or vicarious. As such, these experiences become pertinent to shaping cognitions around illness. For example, one may experience a parent developing a serious illness and have memories of frequent trips to the doctor with them and frightening procedures, that could shape beliefs that ill health is likely as well as debilitating (Hadjistavropoulos et al., 2014).

As discussed in the literature review, the interpersonal model argues that health anxiety in adulthood is shaped by childhood experience. This model posits that traumatic experiences in childhood can shape the likelihood of somatising in adulthood (Noyes et al., 2002). This model posits that early illness experiences can mean that somatising was often reinforced as a way to obtain reassurance, as such this behaviour is carried on into adulthood. These early experiences are theorised to have heightened their fear of separation and reinforced reassurance seeking behaviour (Noyes et al., 2002). This model also specifies the influence of trauma in shaping attachment in childhood, arguing that that these attachment difficulties make care-seeking more likely for hypochondriacal patients.

Research has also found higher levels of sexual and physical abuse in patients who somatise (Barsky et al., 1994). However, none of the participants in the present study reported a link to historic abuse as a causal factor in their health anxiety. We do see from some accounts though, the suggestion of some parental anxiety and perhaps overprotection, both which are presented as causal factors within the interpersonal model (Noyes et al., 2002).

Interestingly for our participants, only one participant identified a childhood illness, Anorexia Nervosa, as a possible cause for her health anxiety. For the majority of the participants, significant health events happened in adulthood. Although it is possible that these participants did experience negative illness experiences or exposures as a child, this is not where they identified the starting point of their health anxiety.

In line with Emma's experience, research has found a relationship between parental health worries and worries exhibited by adolescents and children (Köteles et al., 2015a; Marshall et al., 2007; Wright et al., 2017). According to the cognitive model, health related beliefs learnt in childhood can create a basis for health concerns. This basis can become particularly apparent when the person experiences ambiguous or strange bodily sensations, where one attempts to make sense of these sensations with the beliefs that they hold (Hart & Björgvinsson, 2010). As such, when these beliefs are triggered this can result in the misinterpretation of bodily sensations (Salkvoskis & Warwick, 2001). Research by Koteles et al. (2015) explored the link between parental worries and their children's (14-19 years), focusing on modern health worries, somatosensory amplification and health anxiety. Similar to Marshall et al.(2007), who also explored this phenomenon, children's ratings on these scales were associated with those of their parents. It is thought that these vicarious experiences, or exposure to parental cognitions around health can build the foundations for health anxiety (Köteles et al., 2015).

Familial relationships were not only significant for health events, but also proved to be an integral part of a number of the participants' health fears. Three other

participants described not wanting to go through a process of dependence on their family following a decline in their health.

> *…And I don't want to be like that…just at home waiting to die, so…I'm pragmatic enough not to want to be a burden and I just hope other people around my accept that, but they may not…(Paul, 75)*

Paul's description of himself as 'pragmatic' reflects a belief that not wanting to "burden" his family with his care is the sensible decision. Instead, he wants to make the 'rational' decision to end his own life before this. Kim, 52 discussed her concerns not only about being a burden on her family, but also on society and its health resources.

> *Kim = No no no I cannot be burden to my family I cannot be burden to government no…*
>
> *INT = What does it mean to be a burden to you?*
>
> *Kim= Oh if I am sick I have to go to hospital (laughs)*
>
> *INT = What's wrong with that?*
>
> *Kim = Going to hospital? Expensive (laughs) the hospital it is free for us, but so expensive and so many people, too many people are sick, not enough people to look after you know…it's burden*

Kim described feeling like a burden if she could not support her family by working, in which case she would have to rely on them for financial support. She was particularly worried about being a burden to her sister who is already a full-time carer for her mother. It is interesting to note that both Paul and Kim used the term 'burden'

to describe their families having to look after them. Being a burden implies disruption in daily routines, relationships, and other activities of family members (Cahill et al., 2009). The concept of being a burden speaks to the idea that citizens must contribute to society Most often, this is conceptualised through financial or social contribution. It is unsurprising that participants felt this way, given the regular portrayal in the media of the 'burden' of the "ageing population" (Gorvin & Brown, 2012). Research in this area has demonstrated that groups such as the elderly, ill and disabled are much more likely to conceptualise themselves as burdens (Gorvin & Brown, 2012). Therefore, it is unsurprising that the participants who experienced this concern were the three oldest participants in the present study.

Kim emigrated to New Zealand during which time she was regularly accessing public health services as a result of mental health difficulties.

> *…I really thankful to New Zealand you know. I was causing so much trouble always in and out, in and out (Kim)*

It is important to take Kim's cultural context into account when analysing her narrative. In Asian culture, multiple generations often live together and the family is more likely to care for ill relatives within the home environment if they become sick, and less likely to engage with support services than white European families (Pharr et al., 2014). Her description of herself as 'causing trouble' reflects a belief that sickness creates a burden for others, a belief constructed in her social and cultural context. In line with this, she discussed past experiences of feeling like a burden to her family who had looked after her following a decline in her mental health in the 1990s. Qualitative research in this area has found that within collectivist populations, there is an expectation of families to care for their sick relatives without question

should they become sick (Pharr et al., 2014). As such, we can see the influence of this participant's cultural context on her experience of health anxiety and in shaping some of her anxieties surround her health. However, in this study this concern appears cross-culturally. Similar to Kim and Paul, Lisa, 63, raised concerns over ill health leading to her becoming dependent on her family, and in particular, causing them financial hardship.

> *I don't want like a long, lingering illness, I don't want, you know I don't want to be a nuisance, I don't want to like be dependent and um…you know I don't want to bankrupt the family from treatments and all that kind of stuff (Lisa)*

For Lisa, her concerns about having a long, lingering illness, are not related to the personal difficulty of going through this experience, but rather the influence of this on her family.

> *INT = You wouldn't want him to spend his time looking after you?*
>
> *Lisa = No I think it's a shit life, you know.*

Unlike the participants above who had family willing to look after them and support them should they get ill, Diane described her anxiety over having no one to look after her if she should get ill.

> *…um you know there is no one there, and I think that's you know the fear, that there's no one there to help me to look after me, and I won't be able to do it by myself…(Diane)*

Despite their differences in worries, these participants share fear of the future, and the uncertainty of how their illness could impact them and their family members.

As such, we can see that health anxiety for these participants does not just entail the illness itself and the difficulties this would create, but also consists of worries about how this illness will affect those around them, and how they will cope later in life should they become ill.

Internal

Another important relationship that appeared was that of the relationship between the participant and their own body. Two of the participants described potential events that were more internal or psychological. Kim had a history of mental health concerns and had been hospitalised for these a number of times.

> *…my sister rang me, I couldn't recognise anybody but um my husband and my son, and then um my sister rang me and um…somehow we decided to come to New Zealand because my husband couldn't handle it maybe by himself yes…oh (tuts)…So my brain is rebuilt (Kim)*

Courtney, 18, suffered with Anorexia Nervosa as a child. Most of her concerns around health in her adulthood appeared to be around her shape and her body.

> *Courtney = Yeah so like, with me, I worked out this morning. I usually try like try do, I try keep up with, I try to be healthy in a sense. Like in the past, really before, like its…I did like um…well like I guess I was diagnosed with anorexia, I'm not, I'm fine now just like so it doesn't go with like your…um…yeah I'm fine now, but it's just before I would be very worried about it but there was a period of time when I wasn't but*

now I am but in a healthier way I'm guessing. But I do try to take care of myself in what, in fitness and in what I eat and with my sleep and everything as well, I try to take care of myself overall yep

INT = Why do you um…what…makes you want to care of yourself?

Courtney = So what um, so I guess it's my own opinion of myself, I, like I don't want to get fat obviously and everything but its also it could be how other people view me as well, so that's um…especially like with this generation and age, like being thin, for women is what you want but um most of all its for how I feel secure in myself, like exercising makes me feel good and if I do I don't really feel bad about eating other things

This extract reflects social constructions of 'health' as one of thinness, where one should engage in a rigorous exercise regime and have expected experiences of guilt around food. Courtney's wording "I don't want to get fat obviously" reflects social consensus that to be fat is to be unhealthy, and therefore it is obvious that one should not want this (Sobal, 2017). Courtney spent time in treatment for her eating disorder and had a large amount of interaction with health professionals during her childhood. This bodily focus would be hard to shift in adulthood and seems to be presenting as cognitions of being 'healthy.' Research has indicated the psychosomatic nature of eating disorders, with bodily checking behaviours indicative of both eating disorders and health anxiety (Hartmann et al., 2019). Health anxiety and eating disorders are often characterised by avoidance, anxiety, resistance and lack of gratification (Phillips, 2002). This speaks to the likelihood for overlap with other psychopathologies when exploring the experiences of health anxiety.

Reflexive Note: It was hard to identify whether these concerns were more health related or appearance related, and whether these fit with the purpose of this study at the time. However, on reflection, this study was advertised as "self-identifying" as worrying about your health. For this participant, her body and the shape of it represented her health, and as such any threat to the health of it, through excess fat or lack of exercise, jeopardised her health. As such it seems feasible that she would be anxious to protect her body through means that she believes will keep it healthy.

Two of the participants described the impact of a negative health experience in changing their relationship with their body. In the extract below Paul discusses his ongoing difficulties with chronic illness, and the physical ailments he experiences as a result of these.

> *…that was at a time when the CLL and the detrusor, overactive bladder combined together and that's when I saw your note. Cause I sort of think…god all I think about is different health problems coming at me from different directions and why I was interested in most of the things that worry me, there seems to be no cure, I had minor ones like I still get cramps at night, and I've been on google as you do and they don't know why, they say magnesium but I've been taking magnesium, I still get these jolly cramps, it gets me up in the morning at 5:30 which I'm an early riser so I don't mind that um…but…um…that's in my lower calf muscles, and then for about ten years, about the same time as CLL came along, I had what I think has been described as neuropathy in my feet, in that I get a tingling and a numbness combination in my feet (Paul)*

Um…I was a bit brassed off, a bit annoyed with my body (Paul)

Paul's comments create a sense of him being 'attacked' by his own body, a separation of his 'self' from his body. He feels let down and frustrated by his body, not trusting it to keep itself 'well.' He went on to describe his journey after being diagnosed with Chronic Lymphocytic Leukaemia (CLL).

> *…about ten years ago is when I was diagnosed with CLL, chronic lymphocytic leukaemia, um…which was simply a matter of watchful waiting they call it, I didn't have any symptoms other than a slightly enlarged lymph node in my neck, and that's the only one that I felt and my oncologist at the hospital kept saying "we don't treat you, we don't do anything" (Paul)*

When patients are diagnosed with early stage CLL there is often a period of 'watchful waiting.' This is because patients who are largely asymptomatic in the early stages of CLL (0 to II) are not actively treated until the disease progresses (Butler & Gribben, 2010). Research has highlighted that patients in these early stages of 'watchful waiting' experience levels of anxiety and depression similar to those in active treatment for CLL (Evans et al., 2012). Evans et al. (2012) found the uncertainty around the disease to be highly anxiety provoking for patients, as they do not know how this disease might progress or affect them.

Joanna discussed her increasing somatic awareness following her short-term paralysis. Her paralysis lasted around ten days but she discussed the ongoing difficulties she still has from this experience.

Um well…I have like typical spinal cord stuff – bowel and bladder issues and lower limb weakness, ongoing lower limb weakness (Joanna)

Like Paul, Joanna's experiences of health difficulties have increased her hypervigilance of her body. As a result of these difficulties, both participants have no choice but to remain vigilant of their bodies This maintained vigilance creates an ongoing sense of anxiety, where the smallest change could be a sign of something sinister. These findings run contrary to traditional understandings of health anxiety as a disorder experienced by persons with no physical affliction. In theory, these participants would not have met criteria for DSM-IV hypochondriasis as they are not 'misinterpreting' their symptoms, these symptoms are real and experienced. This brings into question when it is that we need to pathologize illness concerns since, as although their concerns were affecting their functioning, these concerns were perhaps legitimised by their struggle with ongoing illness. However, it also provides support for the recategorizing of health anxiety within the DSM5, particularly for somatic symptom disorder, in which a person has a significant focus on a physical grievance.

Summary

Using the lens of social constructionism to explore experiences of self-identified health worry has demonstrated the importance of relationships in shaping these experiences. Difficult experiences with health were perceived by a number of participants as significant, providing evidence for both the cognitive and interpersonal models of health anxiety. This theme also demonstrates the ongoing influence of medical relationships in shaping health anxiety; in particular the influence of fractured trust in enhancing a sense of uncertainty towards professionals as well as towards their own bodies. It also reflects power dynamics in shaping

participants' urgency to regain control over their bodies and experiences of being judged in adding complexity to experiences of help and support seeking. Familial relationships are often influential in triggering health anxiety, where vicarious experiences of ill health or of illness concern can influence cognitions and expectations around health. These relationships can also shape experiences of feeling like a burden and in crafting concerns over who will take the responsibility for their body should they become unwell. Finally, the participants' spoke of a complex relationship with their own body, constituting themes of uncertainty and vulnerability in their ability to maintain good health and to perceive ill health, as well as a discord between the self and body should they become unwell.

Theme 2: Invalidation

Throughout their interactions with health care providers, many of the participants reported feeling invalidated through the presence and absence of a number of practices. This theme will be broken down into two subthemes. The first of these is 'labelling' which explores participant's experiences of being labelled under the umbrella of mental health. The second is 'not being heard,' looking at experiences of feeling ignored by professionals, and their concerns not being validated or understood.

Labelling

A number of the participants recounted their experiences of being 'labelled' by professionals or by their peers. Two of the participants felt that their experience of physical symptoms was not taken into account because of mental health concerns that they had experienced in the past. As such, they felt that their physical symptoms were labelled as 'mental health issues', meaning that these were not explored further. Claire attributes a lot of her health related anxiety to the experience of being labelled following the birth of her daughter.

> *…that um a lot of my anxiety stems from after the birth of my first child we had a lot of complications, it was a complicated birth, complicated post birth… (Claire)*

Claire discussed feelings of 'labelling' when experiencing concerns that her newborn daughter was unwell.

> *…so I remember thinking back then, something's not right I know somethings not right, I know I'm a new mum, I was a very new mum, I*

was very tired and very anxious, I had postnatal depression which was already I felt like a label that was stuck, I was fine with the diagnosis but I felt like because of that that all the doctors and…threw it off as PND (Claire)

Claire attributes a significant amount of her health anxiety to the experience of seeking help for her child who was ill and not feeling heard or validated by professionals. Claire's statement that professionals "threw it off" reflects her sense that her concerns about her daughter were labelled as related to her post-natal depression and thus were discounted by medical professionals. This extract also reflects that post-natal depression is an enduring label that she remains "stuck" with. As a result of this label she reports that doctors attributed her difficulties to this diagnosis, rather than exploring them as legitimate concerns. Claire went on to report that her daughter was in fact ill, proving her concerns to be valid. One can imagine the sense of unease that you could experience from having your concerns proved right even though medical professionals doubted you. It seems feasible that this would leave you with a sense of uncertainty in the ability of professionals to correctly manage your illness or your child's.

Similar to Claire, Diane also experienced a sense of being labelled following past mental health difficulties.

…if you have even mild anxiety prior to any major or um…health problem…you get labelled…and so you get lumped into the mental health of you've got anxiety (Diane)

Diane's use of the word "lumped" creates similarities with Claire's use of the term "threw it off", reflecting connotations of dismissal and invalidation by health

professionals, where their difficulties are categorised as psychological, despite their complaints that these are physical. This finding supports research by Noyes et al. (2002) who interviewed patients with hypochondriacal concerns. They found that many of these patients felt poorly understood and reported feeling as though they were responsible for their difficulties as no physical cause was able to be found. As such, when problems were physical patients were not to blame, but if they were psychological then the patient was seen as responsible. They also found that when patients had been told that there was a psychological element to their difficulties, a sense of weakness was implied (Noyes et al., 2002). Diane discussed her interactions with health professionals and their perception of her physical ailments as anxiety.

> *So then going back to the doctor, going back, trying, I was literally screaming out for help and then they were all going 'it's all just anxiety, its all just anxiety' that's just what they kept putting it down to and that point yep it was but I didn't register the whole pattern of how it happened until much later (Diane)*

Although we do not know the exact language used by the physician or the participant, the phrase "all just anxiety" is significant. This wording reflects a devaluing the experience of mental illness where it is not perceived to be as serious as a physical illness. It is *just* anxiety. In this way, anxiety is perceived to be not as impactful or debilitating as a physical illness, and as such should be seen as a relief to patients. Diane reflects frustration with medical professionals, as she notes "screaming out for help" and needing to keep "going back, trying." It seems feasible that this behaviour could be interpreted as 'reassurance seeking' or 'doctor shopping,'

where she repeatedly kept going to a medical professional for a physical diagnosis. This again would invalidate the validity of her concerns.

In retrospect, Diane reflects that her experience was anxiety related. However, her doctor failed to explain how this might be playing out for her and it was not explained until months later when she was referred to a psychiatrist. Perhaps if this pattern had been explained to her earlier on, her need to keep looking for cause would have been lessened.

> *Um…so by the time January came around, I was struggling over the Christmas break, my doctor was on holiday, there was no point going back to hospital, I felt very much alone and that I had no one to go to. Where do you go when you're too sick to be at home but hospital won't take you? Um…and so 3rd of January, because of all that and because I didn't know where to go, I had a nervous breakdown (Diane)*

Diane's narrative relays feelings of abandonment by the medical system and an experience of not knowing where she fits within the medical paradigm. In these situations, the physician's initial role and aim is to find the physical cause of a person's ailments and then when failing to find this, physicians often shift to containing excessive help-seeking behaviours (Looper & Kirmayer, 2002). When it becomes clear that the patient does not fit within their disease model, patients are sometimes given a psychiatric referral (Hart & Björgvinsson, 2010). This can often be distressing to patients, as they feel that their physical symptoms have been invalidated and that the experience they are having is 'all in their head' (Hart & Björgvinsson, 2010). However, some patients are not given a referral and as such can become lost within the system, as appears to have been the case for Diane (Hart &

Björgvinsson, 2010). This seems to be a particularly likely outcome for those who may not meet diagnostic criteria.

Despite labelling having negative connotations for some participants, it appears that the experience of labelling can provide comfort for others. One participant described a sense of relief from the experience of being labelled.

> *Sarah=…Errr but I mean I'm happy to say I'm a hypochondriac than to say I experience fits of anxiety about my health, because that makes me sound a lot worse, um…whereas if you just go I'm a hypochondriac I live with that, I consistently think that I'm going to be sick or whatever, or in this case literally am sick (participant has a cold at the time of interview) um…it just…its…because it's used so often it's a bit easier I think to say.*
>
> *INT = So, it's easier to say, because people kind of get what the issue is without you having to explain it?*
>
> *Sarah = Yeah and I think that, there is a little bit of a connotation with hypochondriac with people being a little bit belittling of it…but like I'd rather have someone be like 'ah you know you're just a little bit wound up but heaps of people are like that' than like, people being like 'oh you're crazy.' I feel like you don't get that from hypochondriac you just get a little bit of like lol that's you constantly thinking that you've got a disease, you're fine*

Sarah finds comfort in people being able to label her experience. By addressing herself as a hypochondriac, she gains reassurance from people that she is not sick, that she is "fine." This is a similar finding to that of Beckett (2009), who

conducted a qualitative study of the experience of seven participants who were experiencing health anxiety. Three participants in the study reported that to be perceived by family and friends as a hypochondriac means that they are not taking your concerns seriously, and as such, you are likely not ill. Therefore, like Sarah, the participants in Beckett's (2009) study found stigma from family and friends to be reassuring. Aside from Sarah's contentment with this label, no other participants in the present study identified reassurance from the label of 'hypochondriac.'

Paul seemed particularly interested as to whether people perceived him to be a hypochondriac.

> *I mean when my GP says oh I don't think you're a hypochondriac, I thought oh good he said that (laughs)(Paul)*

Unlike Sarah, Paul did not want to be labelled as a hypochondriac. For Paul, reassurance comes from not being labelled as a hypochondriac. Perhaps Paul felt that being perceived as a hypochondriac could invalidate his experience of CLL. Later on, when he was asked for his reasons for being part of the study he replied:

> *…maybe I wanted reassurance that I wasn't a hypochondriac, could be that, or you might go away and write all that he's a hypochondriac and he doesn't believe he is (laughs)(Paul)*

It seems that one of this participant's motivations for being part of this study was that he might be told that he does not fit the 'mould' of the hypochondriac.

> *…and that's why I wondered if should even be here…(Paul)*

Prior to our interview this Paul sent an email detailing some of the physical health complaints he was experiencing and concerns that he would not be a suitable

candidate for the study. His concern reflects the social construction of what a hypochondriac is, a person experiencing no physical complaints, who repeatedly goes to the doctor worried about illness, a person with an absence of illness. However, he can see that these concerns can be held by people with and without physical symptoms. As such, this falls in line with the new DSM-5 model of health anxiety, which identifies two disorders; one with physical symptoms and one without.

Reflexive note: In hindsight, I wish I had delved deeper into Paul's reflections here. What it means to him to be considered a hypochondriac? Did he worry that people would not take his legitimate medical problems as seriously? Was he embarrassed that people could potentially think he was malingering? What does it mean for him if his GP thinks he is a hypochondriac, and what does it mean that he told him he was not? Perhaps being labelled a hypochondriac means that this is the final label given to his medical concerns, some of which still remain undiagnosed. If these symptoms could be explained by 'hypochondriasis' then further medical investigation would likely not be done (Starcevic & Lipsitt, 2001). As such, the ramifications of this term are significant.

Not Being Heard

Many of the participants experienced frustrations with their concerns being dismissed or ignored.

Diane discussed her repeated visits to the A & E as a result of the physical sensations she was experiencing, which she believed were a result of the anti-depressants that she had been prescribed. She described repeatedly being told that she was "fine" and sent home. On one occasion she called an ambulance because of the distress of physical sensations but, as her vital statistics were fine, the ambulance

refused to take her to hospital. As a result of this repeated sense of 'not being heard' she called an ambulance and feigned a stroke as a means to be seen in hospital.

INT = So how did it feel when you felt these physical sensations, and they were telling you that it wasn't…

Diane = Oh well that's when the anxiety just got worse and worse, because I wasn't being heard I was told that it was all anxiety related, when at that point I didn't have the anxiety, I was just feeling these physical symptoms. So the fourth time, which was now five weeks later from when it started I was at work and my right side went weak, now I'm not silly and I knew that they'd have to take me because I'd be a potential stroke. So I played on it, it was the only way I knew I was going to get into hospital, so I had called an ambulance again, the right side of me did go weak but it wasn't as weak as what I made out it was, so they took me straight to hospital.

As detailed above she felt that her physical symptoms had been so invalidated by health professionals that she ended up exaggerating her symptoms to suggest that she was having a stroke, as she knew the paramedics would have to take her to hospital. As such, Diane's experience was almost a self-fulfilling prophecy, as she had to feign illness as a means to seek help.

Joanna also described the long term impact of 'not being heard' by professionals had on her life.

> *Which is what I don't like about like the medical…someone in authority did something to me, didn't listen to me and did something to me and it had a profound impact on my life (Joanna)*

Joanna felt that she was harmed by health professionals, as a result of the trauma following her epidural and then consequently being ignored by them. This extract relays a sense of powerlessness in her experience, where something was done to her, and her concerns regarding her own experiences and her body were not heard. Diane also spoke of the enduring impact of not feeling heard by health professionals.

> *…when I went home though, but because of having that five weeks of not being heard that's when the anxiety started to build up, so when I got home it morphed into anxiety (Diane)*

Diane reported that her anxiety was not present before experiencing these physical sensations, but rather evolved as a result of "not being heard" by medical professionals. As such, the feeling of not being heard was the trigger for her ongoing anxiety. Research has found that frequent emergency room attenders are often put on a time-out by physicians, where the person has to wait a long amount of time to be seen in a bid to stop them repeatedly returning (Asmundson et al., 2001) However, such a dismissive approach can often make these patients feel like they are not getting the care they need. In response to this, a person's belief that they have an undiagnosed condition can be strengthened (Asmundson et al., 2001). A dismissive approach can drive the patient's concerns that they are not getting the appropriate care, as such causing heightened experiences of anxiety and an increased propensity to engage in reassurance seeking behaviours (Asmundson et al., 2001).

Emma discussed the concerns she feels when her GP cannot provide her with a viable reason for her physical symptoms

> *Emma=…especially with my GP if he can't find the reason why I'm always going to think in the back of my head, like what if this develops*

into a huge problem in the future. So one of the things I searched up is that I might have appendicitis or a stomach ulcer and stomach ulcers need to be removed like what if it's left too late and I develop stomach cancer, it's just all the build up

INT = So it feels like it's a rolling ball, and it's getting worse and worse and worse?

Emma = It's like a snowball, and it picks up the snow and it gets bigger

Emma does not appear to find the fact that her GP has found no physical problem reassuring, instead seeking a physical explanation of her own. Her analogy of the "snowball" implies the impact that this lack of diagnosis has on her levels of anxiety, as the snowball starts to roll, picking up more and more anxious thoughts.

When people with health anxiety are not given a 'valid' explanation for their problems by their physician, they often blame the physician's lack of thoroughness or knowledge (Persing et al., 2000). In line with this, Emma discussed her views on her GP's knowledge.

Emma = Yeah I've asked multiple times 'oh why is this happening?' and then he'll be like 'oh maybe from this, maybe from that' but it's never like confident, it sounds like just rambling um…I think that's my main issue

INT = you'd like something concrete? And this is what's going on?

Emma = Mmm…yeah, because if it's been happening to me for years, you kind of start to be like why, and especially doing nursing it gets me even more aggravated because if I can come up with so many diagnoses

for just a couple of symptoms, why can't he just come up with at least one logical reasoning behind why I'm always sick with this stomach thing?

Emma relays the frustration that can often emerge in interactions with doctors and people with health anxiety. It appears critical that doctors provide concrete reasoning for their experience of symptoms, even though conceivably these symptoms may not be attributable to any physical ailment. These comments also speak to the assumption that the doctor holds knowledge which has power over their experience of these symptoms, as well as power to legitimise their experience. Participants in Persing et al.'s (2000) study reported feeling rebuffed when follow up testing was not done. For these participants, reassurance from the physician when there was no medical testing involved provided little comfort. Instead, these participants became concerned that the doctor was overlooking something. As a consequence, as can be seen in Emma's case, many of the participants became knowledgeable about diseases that they might have, or treatments that they might have been given (Persing et al., 2000).

Summary

Participants' experiences of invalidation by health professionals had a significant impact on their experience of health anxiety. Although participants did not describe making deliberate attempts to frustrate their physicians it was evident that there was often strain in these relationships. The attribution of their symptoms to prior mental illness left many feeling as if their problems were not important, and sometimes left unable to access a service that would cater to their needs. In no case does it appear that any diagnosis of illness anxiety disorder or somatic symptom disorder was made. For these participants, not being heard meant that their anxiety

escalated, as they believed that their problem may not be found or responded to until it was too late. As such, we can see the impact of invalidation on snowballing participants' anxiety.

These findings provide evidence that patients would benefit from some psychoeducation around the spectrum of health anxiety, perhaps supported by information surrounding the link between physical sensations and anxiety. Discussion around this could be initiated in session with the client and supported by providing the patient with psychoeducation literature. These findings provide evidence for the need to include the interpersonal relationship with health care providers in the treatment of health anxiety. These findings speak to the importance of trusting the therapeutic alliance with the physician, as well as on clear communication on likely improving the patients' ability to manage their anxiety (Williams et al., 2010).

Theme 3: Insight

This theme explores participants' insights into their health, as well as the way in which they felt their concerns were perceived by health professionals. This theme comprises two subthemes. The first of these is 'seeming like a repeat guest,' which captures participants' perceptions of health professionals. The second subtheme, 'being irrational', speaks to the ego dystonic nature of participants' health concerns.

'Seeming like a Repeat Guest'

The majority of the participants described a sense of responsibility for the often challenging interactions they had with health care professionals and discussed ways in which they attempted to manage these.

> *…but yeah I just I'm consistently worried that I'm being annoying to the healthcare professionals so I try to stay out of their lives and just sit here and worry for a little bit (Sarah)*

Sarah describes how she attempts to manage her internal battle.

> *Um…I usually put it off if there's something where I'm not sure if I need to go to the doctors or not, I try to put it off a bit, because I feel like I go too much, or when I do go I'm a little bit of a high maintenance one (Sarah)*

Sarah maintains acute awareness of the way that she might be perceived at the doctor's surgery. As such, we can see that this participant attempts to manage her own anxiety internally and does not always seek reassurance from medical professionals.

Claire also shared her concerns of being judged for going to the doctors too often.

> *…that maybe because I'm so conscious of my health anxiety, that I worry so much about what people would think if I'm at the doctors once every few weeks that…that I stress myself more by oh gosh I've got something wrong with me but I'm too…it's funny I don't ever rush in to the doctor, I always try in my mind, I always play it down I always try reassure myself for weeks and weeks on end until I can't take it anymore and I go.*
> *(Claire)*

Claire's use of the label 'health anxiety' relays her allegiance to the diagnostic criteria. It is interesting to reflect on whether she would have used the term 'hypochondriasis' in the same way. From this extract one can see Claire's concern regarding the way in which she is perceived by the doctor. This strategy of avoiding the doctors and attempting to reassure herself has an escalating function. This challenges the current conceptions that repeated health seeking from medical professionals escalates reassurance behaviours. In contrast, this study finds that health anxious patients often avoid the doctors, which in turn escalates their anxiety. In this way, the doctor's invalidation and the patient's lack of willingness to go to the doctors are co-constituting a problematic interactional pattern.

> *I mean she was the girls GP, but I ended up, you know I did change, because…I don't feel like it's the doctor's place to make me feel like that especially when I'm a parent, it's not like I'm going I mean, sometimes it is weekly if I'm getting week after week of sicknesses then I do feel like we're there all the time, and then we go months without seeing them.*

Um… so that made me feel like she would judge me every time I went (Claire)

Claire attributes anxiety to feeling judged by her doctor, to the extent where she had to change her doctor. It is interesting to consider that in this moment, Claire seems to justify the amount of times she goes to the doctor to the interviewer, perhaps experiencing a parallel in her experience here.

Joanna also discussed her experience with medical consultations.

Joanna = and you know I should have it at my GP but I decided not to have it at my GP and decided to go to family planning because a friend had talked about a really good experience that she'd had at family planning

INT = So you were worried that you might end up having a bad experience with your GP?

Joanna = Yeah I mean…I don't know I just sort of it sounds ridiculous but I don't know that I want…like…I feel like I'm over exposing myself to my GP in some ways and I didn't want that so I kind of liked going somewhere else and being anonymous.

When asked why she felt like this she replied:

I think my privacy has become quite important to me as well and I felt like going somewhere else would make me a little bit more anonymous but it also made a bit more fearful because…there was no relationship to trust on but when I thought about getting it done I didn't feel comfortable

about going to my GP either…it's not logical it's not about logic for me it doesn't make sense? (Joanna)

This participant's feelings of losing her "privacy" likely stem from the amount of professionals involved in her care, and the vulnerability she experienced during her paralysis. As a result of this, having her smear at a place where she was not recognised seemed appealing. Like the participants before, she may too have felt that she was going to the doctors too much, or "over-exposing" herself. However, she did not directly attest to this. Interestingly, this participant also talked about the importance of the trust in her decision to go to family planning, but her need for privacy outweighed this.

These three participants have all considered the way that they will be perceived by the doctor if they go 'too often.' They attempt to avoid going to the doctor and instead employ other strategies such as giving themselves a time-limit or using a different service. As mentioned above, this troubles the notion that people experiencing health anxiety simply run to the doctor. Instead, these participants describe a high level of insight into how they might be perceived and work to avoid this.

Conroy et al. (1999) investigated the relationship of health anxiety to patients' frequency of general practitioner visits as well as their expectations of the visit. Their findings indicated that those with higher scores on the Health Anxiety Questionnaire were more likely to consult with others before going to their doctor. This suggests a process of social comparison, where the person attempts to see if their problem is worthy enough to go to a doctor (Conroy et al., 1999). This study's participants also feared judgment from their doctor if their problem was not deemed as serious enough

and highlights the need for validation by others and the doctor of one's illness experience. Consulting with another person, likely a friend or family member, prior to their doctor's appointment appeared to be a space where participants felt less judgment.

It was of note that participants mostly described their experiences with health practitioners negatively. However, one participant discussed her positive experience with a neurologist that she met after going to A&E when she believed she had a blood infection in her brain.

> *The head neurologist came to see me and she said "look we think it's actually anxiety, we think you're stressed" she made me take 14 days off work. She was so great, she was so good, she not once made me think I was stupid, or wasting her time, and she actually called me about a week later, checking in to see how I was doing (Claire)*

Even though Claire was told her problems were psychological rather than physical, Claire felt validated in her experience with the neurologist. Barsky (1991) suggested that to be perceived by others as 'medically sick' people must become a patient and get a diagnosis which entitles them to all of the 'privileges' of sickness, such as time off work or disability allowance. Perhaps, by prescribing Claire 14 days off work, her sense of being unwell was 'validated' by this professional, and her 'sick role' was confirmed to her.

'Being Irrational'

As discussed in the literature review, research so far indicates that people with hypochondriacal beliefs demonstrate a lack of insight into their anxiety. When

comparing people with OCD to those with health anxiety, those with OCD were found to demonstrate much higher levels of insight than do those experiencing health anxiety (Abramowitz & Braddock, 2006). The participants in this study, however, challenge this idea, demonstrating high levels of insight into their concerns and how these emerged. However, it should be noted that these participants may be benefitting from hindsight, as participants were able to reflect more objectively on their experience outside of its original context.

> *Claire = And I remember that week after week it was this one thought that kept bothering me and she said why don't you just get it checked out, and I knew that because once I get it checked out I'm obviously not going to have bone cancer and it would just be something else.*
>
> *INT = So you had an awareness at that time that it was irrational?*
>
> *Claire = Absolutely yes*

Claire's extract demonstrates insight into her anxiety at this time, where she knew she "obviously" would not have bone cancer, suggesting a high level of insight during a time of anxiety.

> *Absolutely yes and I think…I think when I am well-rested and taking care of me that even when I'm anxious I know that these are irrational thoughts. It...it… you know my gut feeling is that I know that these are irrational but when I am stressed and tired and for weeks and weeks on end as you are with two young kids that this is when I can 100% convince myself that this is what I've got… (Claire)*

Claire creates a differentiation between her feelings of stress and anxiety, placing stress as the trigger to an anxious experience. For Claire, a lack of stress means that she is able to look at her anxious thoughts more objectively. As such it appears that her insight is not a stable experience, but rather one that fluctuates depending on the context.

Similarly, another participant discussed her insight during an anxious episode.

> *…at that point I called Healthline and was like I know that this is dumb, I just need you to, I just need you to tell me that I don't have DVT (Sarah)*

If this experience was interpreted using the cognitive model, this participant would be regarded as engaging in reassurance seeking by using *Healthline* as a means to confirm that she did not have DVT. However, we can see from this extract that at this time she had insight into her anxiety process. As such, Sarah's views on the situation were not narrowed by her anxiety; instead, she was able to look at them through a critical lens even though she continued to engage in the process of reassurance seeking. Findings by Beckett (2009) relayed that participants also demonstrated some awareness of the 'irrational' nature of their concerns and spoke of the embarrassment they felt going to the doctors on multiple occasions.

> *Joanna= not really, because actually at a rational level I feel like a lot of my concerns are ridiculous but it doesn't make them any less real to me in the moment. But now like you know as I say it to you I had a headache I thought I had a brain tumour that's so stupid like but in the moment it's very real and overwhelming to me so yeah…*
>
> *INT = What does it feel like?*

Joanna= really scary, really, really overwhelming

Unlike Sarah's descriptions, Joanna discusses the "real" feeling of these concerns when she is consumed in her beliefs. Her level of distress highlights the lack of insight she has in these moments.

Emma reported often experiencing health related symptoms at times of high stress.

INT = you find you get sick quite a lot? How often do you think?

Emma = At least ah…maybe once a month?

INT = Ok yeah so that's quite a lot

Emma = Yeah but it's not like long periods of time it's just stress and then as soon as the stress is gone I'm like better the next day, but it's like…awful

In Beckett's (2009) study, one participant also reported experiencing physical symptoms at the time of stress over assignments and would regularly visit her doctor during these times. Beckett (2009) suggested that these behaviours might serve a function, perhaps in terms of reassurance or as a means to avoid the stress of assignments.

Comparison

For some participants, comparison with others helped to shape their own understanding of their experience of health anxiety. One participant discussed her beliefs surrounding the irrational nature of other people's health concerns.

…Yeah and you just can't help it and I'm on a health anxiety page for hypochondriacs and even reading stuff like that I'm like 'how on earth did you come to that conclusion'…(Claire)

It is of note that this participant does not describe other people sharing their stories as particularly triggering for her own health anxiety. Instead she is able to view them more objectively. This once again speaks to the idiosyncrasy of experience in this area, with some people with health anxiety viewing other people with health anxiety concerns as irrational. There is little research exploring Facebook support groups for people with health anxiety and further qualitative investigation into these groups could be beneficial.

Sarah discussed her mother's influence on her cleaning habits.

INT = What happens if you don't clean the desk?

Sarah = Then I wouldn't touch it cause it's like the dirty part of the desk, so you'd like shrink into the corner away from the dirty part

INT = so you're quite aware that that is dirty?

Sarah = Yeah, yeah, which is very similar to the way that my mother lived, but a little less restrictive I like to think, um…

During the interview, Sarah repeatedly referred to her mother, and how she has impacted her behaviours and belief systems in both childhood and adulthood.

Research has explored the critical role of social comparison in influencing our perception of health threats, as well as how we seek help and when we seek help (Tennen et al., 2000). This research has been particularly prominent in chronic illness,

where people look to others with the same diagnosis to compare areas such as their adjustment and coping skills (Cabrera-Perona et al., 2017). There has been little research exploring the role of social comparison in health anxiety. However, the significance of comparison in our results speaks to findings by Beckett (2009). Beckett (2009) also found that participants would compare themselves to others, often attempting to differentiate themselves from other sufferers.

Summary

It is apparent that the participants demonstrated high levels of insight into their experiences of health anxiety, both at the time of anxiety and in hindsight. As such, this challenges perceptions of people with health anxiety as displaying little insight. Many of the participants also engage in social comparison, where they can place themselves along a spectrum in relation to others. As such, the importance of exploring this phenomenon through a social constructionist lens is highlighted, bringing attention to the importance of others in shaping participants' experiences.

Theme 4: 'Better Safe than Sorry'

This theme explores the precautions taken by participants to protect their health. It is broken down into four subthemes: The first of these is 'Dr Google,' discussing participants' use of the internet to make sense of their health concerns. The second is 'checking,' exploring how participants attempt to reassure themselves that they are well. The third, 'responsibility for health', considers the influence of social constructions of health and how these shape feelings of responsibility for 'wellness.' The final subtheme, 'avoidance', discusses how some participants avoid situations in order to manage their anxiety.

Dr Google

All participants discussed using the internet as a means to access knowledge about their health. As such, this finding aligns with research that indicates that internet use for health-related searches is higher among health anxious people (Singh, 2020). Despite wide usage of the internet for health-related purposes, a number of the participants noted that they did not find the internet reassuring, and that it in fact made them more anxious.

> *…and then I would google which would obviously distress me more I don't even know half the time why I would google but it would either be to reassure me, I don't know, that maybe there is...to almost reassure me that maybe I am in that position, like to reassure me that there is something wrong with me as much as I didn't want something to be wrong with me…or sometimes it would be that I would go online to try and change my mind and to reassure me that I don't have anything wrong*

with me but of course when you google everyone's got cancer, no one talks about their nice experience of having lumps on their leg (Claire)

Claire reported using Google both to reassure her that she has an illness but also to reassure her that she does not. Claire "needs an answer" regardless of what this is, falling in line with previous research demonstrating the high levels of intolerance of uncertainty in people with health anxiety. Singh et al. (2016b) found that people can experience both positive and negative metacognitions whilst searching for health information. For example, Singh found that, regardless of knowledge around the disadvantages of internet searching, some participants needed to know the answers nonetheless. They also found that participants had positive metacognitions, such as 'better to be safe than sorry', indicating that searching the internet for health information gave participants a sense of control over their fate (Singh et al., 2016b).

As discussed in the literature review, 'Cyberchondria' is a term used to describe frequent and extensive internet use for the purposes of searching for medical information that is accompanied by significant anxiety and/or distress (Norr et al., 2014). As medical searches often provide numerous possibilities for physical symptoms, these searches usually prove unsuccessful in their attempts to reduce uncertainty, often leading the individual to continue to search for further information to alleviate the sense of uncertainty (Norr et al., 2014). In the extract above, Claire describes how googling her symptoms would cause her further "distress", linking to this concept of Cyberchondria, where attempts to alleviate anxiety with searching medical symptoms have proved fruitless and have served to enhance her anxiety further.

Another participant discussed using the internet for information surrounding unfamiliar physical sensations, in this case, pain in her calf. She reported an ongoing concern that she had Deep Vein Thrombosis (DVT) so was concerned that this pain in her calf was a symptom of this.

> *I was lying in bed and the back of my calves hurt, particularly one calf, and I was like ah nooo this is it, it's coming and then like I looked up, I googled which you shouldn't do some other stuff that you know could in theory lead to like some symptoms, and I was like I have none of these I'm fine and I go back to bed and then like, but do I feel like a little bit of pins and needles maybe, but like maybe not, and then I believe at that point, because this happens, not very often, but at that point I called Healthline and was like I know that this is dumb, I just need you to, I just need you to tell me that I don't have DVT (Sarah)*

Initially googling the symptoms for DVT was enough to reassure Sarah. However, we can see that quickly after deciding that she was "fine" she begins to doubt herself. This experience culminated in her seeking reassurance from *Healthline*, a 24/7 telephone line with registered nurses. In this case therefore, the internet provided short-term reassurance for her but eventually she sought further reassurance from another source. This finding falls in line with the concept of 'threat-confirming bias' within health anxiety (Baumgartner & Hartmann, 2011).This attention bias may potentially cause health anxious individuals to only attend to threatening information, at the cost of ignoring positive information, potentially intensifying their anxious feelings and thus leading them to engage in further reassurance seeking behaviours (Eastin & Guinsler, 2006).

The participant above initially viewed information that was potentially 'non-threatening' but possibly her heightened bias towards negative information led her to seek further reassurance through contacting *Healthline*. It is also of note that this participant says that she used Google which "you shouldn't do." As such, Sarah demonstrates an awareness that googling symptoms enhances medical anxiety, yet she goes on to use Google as a means to attempt to alleviate her anxiety. As such, Sarah appears unable to tolerate her anxiety. This speaks to research surrounding intolerance of uncertainty (IU) and anxiety sensitivity (AS). Research suggests that online health information seeking can lead to higher levels of health anxiety in individuals with higher levels of IU (Norr et al., 2014). Research indicates that continued exposure to health information serves to maintain and enhance health anxiety (Norr et al., 2014)

Joanna discussed how the internet sometimes provides reassurance to her and sometimes does not. As such, it appears that careful attention needs to be paid to the context of online information seeking.

> *Joanna = Oh yeah I do google things but I've been doing it less lately because I've been so tired, yeah I'm just too tired. I do google though and I see that like one in like ten million people get brain tumours so I'm like it's probably just a headache*
>
> *INT= So it's quite reassuring sometimes?*
>
> *Joanna = It can be, other times it can freak me the hell out*

Results from one non-clinical study indicated that 50% of people experience increased health anxiety as a result of using the internet and approximately 40% noted

decreased anxiety (White & Horvitz, 2009). Commentators reported that this disparity in effect may occur in the same person on differing occasions (Starcevic & Berle, 2013). This finding fits with Joanna's experience of fluctuating experiences of reassurance from the internet. Research indicates that this fluctuation may be influenced by the type of information found during these searches. Singh and Brown (2016b) also found that participants reported disadvantages in the use of the internet for medical information. Participants often found information concerning and alarming and reported often being overwhelmed by the amount of information available. However, Singh and Brown (2016b) found that their participants felt that the possible benefits of reassurance outweighed the costs, even though participants recognised that this reassurance was often short lived.

In line with Singh and Brown's (2016b) finding that people are often overwhelmed by available information, Emma discussed the wide variety of explanations for her health concerns on the internet.

> *…it just made me more anxious because there were so many possibilities. But then it also made me a lot more angrier at my GP, because I feel like ok if the internet can come up with so much stuff, why can't you come out with at least three different things that could be possibly wrong? (Emma)*

Emma uses the internet as her first filter for her symptoms before seeing her GP. Research has found that the increasing use of the internet by patients has contributed to a growing level of dissatisfaction in the relationship between doctor and patient (Tan & Goonawardene, 2017). Research has suggested that the rapidity, ease of accessibility and wealth of information has caused more people to use the

internet as the first line of information before seeking professional help (Tan & Goonawardene, 2017).

The large amount of information, and the dubious nature of a large proportion of the information available online, indicates some likely difficulties. Research exploring information searching for health related information has indicated a number of factors that people look at to determine credibility, such as the author's qualifications, writing style and layout (Eysenbach & Köhler, 2002; Singh & Brown, 2016). The accessibility of information has resulted in patients feeling more empowered when speaking to their doctor around their illness (Tan & Goonawardene, 2017) When health anxious patients' online searches do not align with the options suggested by the GP, they often become dissatisfied with the outcome of their appointment (Tan & Goonawardene, 2017).

A meta-analysis by Tan and Goonawardene (2017) found that patients were more satisfied with their relationship with their physician when they were given the opportunity to discuss health information that they found online. Their results indicated that frustrations emerged when they experienced resistance from their physicians when attempting to discuss this information. As such, this demonstrates the need for doctors to engage with the information that patients provide to them and to engage in a collaborative approach when working with health anxious patients.

Paul also uses the internet as his first source of information, prior to seeking medical advice from his doctor.

> *…I must admit, Googles almost become my source, in which I then check with the doctor um…so I would act on it rather than being anxious about it (Paul)*

The ease of access and rapid ability to seek some understanding of his symptoms from online information proves beneficial to Paul and allows him to feel pro-active in his health. However, Paul still goes to his GP and does not rely solely on the information provided online.

Only one of the participants talked about the influence of social media on their health anxiety. Claire discussed some positive and negative experiences with social media sites such as forums and Facebook.

> *…there's a really good website called No More Panic, and, so most of the time these days when I Google I actually Google 'breast lumps no more panic' so it will come up with a forum from that website which I think is for anxious people pretty much (laughs) to talk about what makes them anxious, and most of the time I think it is very reassuring, it is just a community of people trying to convince each other, well help each other out and reassuring each other that it is just nothing…(Claire)*

Claire describes using the internet not only as a reassurance tool through 'Dr Google' but also for seeking reassurance from other people experiencing similar anxiety. It seems it is less about googling but rather more about what is actually googled and consulted. Research exploring the role of forums in health anxiety has been limited. Singh and Brown (2016b) reported that forums were a popular resource for information searching for their health anxious participants. These were often used when their participants had a 'non-serious concern' as these were viewed as less credible resources than other health pages (Singh & Brown, 2016b). The limited amount of research in this area, and the ever increasing use of social media in

everyday society indicates that further research into people with health concerns use of social media for reassurance seeking would prove useful.

Claire used numerous sources of social media for reassurance. She described her concerns about her child having Leukaemia and the reassurance that she found from following a mother of a child with Leukaemia on Instagram.

> *Claire=...but you know what did make me calm down a bit was a mum on Instagram who I'd spoken to um years ago when our firsts were born. Her little girl who is the same age as my first she ended up having Leukaemia, and she's fine, she's currently going through chemo, but that was a real eye opener for me to realize that I have never considered that…*
>
> *INT = That it might be alright?*
>
> *Claire= That it might be alright.*

Claire's interaction described above allowed her to challenge her catastrophic thinking. However, despite having some positive experiences from interactions with social media, she also found that social media often increased her anxiety.

> *…last year I worried that my youngest girl had something wrong with her um to do with her genes since birth that they didn't pick up on, I was convinced that it was some kind of disorder that she would be prone to cancer. So I had immersed myself in this, I had joined Facebook groups of parents of kids with the syndrome, I um got so consumed into it (Claire)*

In the extract above, Claire describes anxiety that her child was suffering with Beckwith Wiedemann syndrome. Beckwith Wiedemann syndrome is an overgrowth disorder characterized by an increased risk of cancer and certain congenital disorders such as a large tongue and microcephaly. Claire joined a Facebook page for mothers of children suffering from this as a means to gain support for raising a child with this syndrome, and to understand more about the condition. Her daughter had not been diagnosed with this syndrome. Claire describes her 'immersion' in this page, alluding to the frequency and time spent on this page. Her continued exposure to these narratives served to further strengthen her belief that her child was unwell.

> *Claire =So then I spoke to this lady from the Beckwith Wiedemann New Zealand group (Facebook), who said to me, I asked her what she thought about the result, and she said to me that looked like she possibly, she probably does have Beckwith Wiedemann (deep breath) and so with all those things combined.*
>
> *INT = So she was not a mental health? She was a…*
>
> *Claire= No, she was just um, I think her son or something had Beckwith Wiedemann syndrome.*
>
> *INT = but she wasn't qualified in any way?*
>
> *Claire= no not at all*
>
> *INT = so why do you think you sought her reassurance there?*
>
> *Claire = because she had gone through what I thought I was going to be going through*

It is interesting to note that when discussing this, this participant took a deep breath. Perhaps this signals the intensity of this anxiety at the time, or perhaps it signals the underlying anxiety that still remains for this mother regarding this disorder. That even saying something out loud might make this a real prospect for her daughter. This extract demonstrates how solidified Claire's belief that her child had this condition had become. Despite reassurance from doctors that her child did not have this syndrome, she sought reassurance elsewhere. Potentially, in one sense, she 'doctor shopped' by asking another person to confirm what she felt she knew. The concept of intolerance of uncertainty presents again in this extract, where Claire found reassurance in working to understand what her future might look like. As such, she could see what this syndrome might mean for her and her family, providing her with an enhanced sense of control over her perceived inevitable fate.

Checking

Two of the participants discussed ways in which they could check their bodies for signs of illness. Claire discussed a number of ways that she would check her body for cancer.

> *…like last year when I thought I had cancer, I would feel on my leg and then I would feel a lump on one leg and I would feel up the other leg trying to see if there was a lump matching on the other side. I don't know why it's probably totally irrational but I think that if it's (laughs) symmetrical then obviously it's probably nothing (Claire)*

Claire's tendency to check her body as a means to reassure herself is a common one shared by people who have health anxiety. Claire uses checking to

determine her risk of having the illness that she fears. In the cognitive model, this behaviour fits within the bracket of a 'safety-seeking behaviour.'

When Sarah rang *Healthline* with fears that she had DVT, a nurse told her that she could kick her leg out to see if she has a pain in her calf. She now uses this kicking test as a means of reassuring herself that she does not have DVT. Another fear that she discussed is having a stroke, and so in order to test this she smiles to see if both sides of her face are moving.

> *…now I kick, do my kicking, and when I was, if I was ever concerned about a stroke I'd look in the mirror and smile and be like yes! Both sides of my face are talking to each other, we're fine! (Sarah)*

Like Claire, Sarah uses these checks to determine whether she has the illness that she fears. This technique provides Sarah with an easily accessible way of gaining reassurance, serving to reduce her anxiety at least temporarily. This has formed a cycle of short-term reassurance. These behaviours become a relied upon sense of relief that Sarah can use, almost like a medication.

Claire discussed checking her children's bodies for potential abnormalities.

> *And the same goes for the girls, I think I felt a lump on one of their heads whilst putting them to sleep, and it is instant panic…instant panic…um so I would feel on the other side, or I'd go find the other girl and feel her head to see if there's, and so far it's been completely fine (laughs) but like but that's pretty much how it goes um…(Claire)*

Claire's description of instant panic suggests the level of anxiety that she is experiencing, where a small abnormality can trigger her instantly. Interestingly,

Claire was the only participant who reported a high level of concern about her family's health, with the other participants describing anxiety only about their own health.

In the extracts above, we can see that participants have created rules that provide them reassurance. For example, if you can smile on both sides of your face, you're not having a stroke, or if something feels symmetrical then it is ok. These rules serve as accessible safety seeking behaviours that they can employ at any time in any context.

> *So, she had this thing where she stuck, her tongue hung out all the time...um…I didn't I think when I googled it I know that I didn't think it was going to be anything sinister, I thought maybe she'd need speech therapy or something of those lines, that's what I was more searching for. But it came up with something called Beckwith-Wiedemann syndrome which was um...a combination of symptoms that meant that they had something wrong with them genetically, and it meant that in kids with Beckwith syndrome, were more prone to I think liver and kidney cancer and so they actually end up screening them every month, they have six weekly blood tests and three monthly scans. So - my youngest, she was nine months by the time that I found this is out and I thought oh my goodness she's had this syndrome for nine months and she's probably got liver cancer because we obviously never screened her…(Claire)*

The rapidity of Claire's speech when describing this experience emphasized the anxiety and distress caused by this experience and reflects her anxiety in retelling this narrative. She described googling some symptoms for her daughter and finding

that these can be symptoms found in Beckwith-Wiedemann syndrome. The participant then sought private care for her daughter and eventually was informed by a paediatrician that this was not Beckwith-Wiedemann syndrome. However, in line with the discussion earlier, this reassurance was short-lived and she recalled repeatedly asking the doctor to confirm that it was not Beckwith- Wiedemann syndrome.

Research has begun to focus on the emerging concept of 'health anxiety by proxy' (Lockhart, 2016). This term is used to describe a parent's preoccupation with concerns about their child's symptoms and fears that doctors have missed a serious illness in their child (Thorgaard et al., 2017a). Two recent studies have found that compared to mothers with chronic illness and healthy mothers, mothers with high health anxiety report their child as having more physical symptoms (Thorgaard et al., 2017a; Thorgaard et al., 2017b). Research indicates that mother's with health anxiety view their child as more ill and present the child more often to healthcare services. Claire's narrative fits with research on 'health anxiety by proxy' where parents often fear that the doctors have missed a serious disease in their child (Lockhart, 2016). As such, these parents are more likely to seek repeated reassurance from medical professionals for their child, in the same way that they might do for themselves.

Responsibility

Four of the participants discussed a feeling of responsibility for their own health. The two youngest participants put the most emphasis on this, discussing the need to protect their health not only for the present but also for the future.

> *…like the government is giving guidelines and everything so they can make themselves better, but if they don't follow them that's kind of like, if*

they get health problems because of that in the future or at present, that's their own…cause it's their own choice (Courtney)

Courtney's commentary indicates beliefs that we hold responsibility for our own health and suggests that we can control the status of our own health. This finding links to the earlier discussions surrounding 'healthism.'

Emma= I reckon just having a good diet, exercising, having enough time outside would probably prevent it a lot more, like I would probably get sick, but hopefully not as much.

INT = and do you think it's important to do things that might prevent illness in the future?

Emma = Yes very important, I think time is crucial, and I think whatever you do has an impact on the future, so if you're not taking care of yourself now what says you're going to take care of yourself later.

Both Courtney and Emma report a sense of responsibility for their own health. Emma's discussion of a "good diet" and "exercise" falls in line with the social expectations placed on us as individuals to implement measures to maintain our health and to protect it in the future. This speaks to the concept of 'healthism' where individuals are posed as responsible for their health. In this way, individual health becomes essential to a person's worth, with non-adherence to recommended guidelines placing you as a 'bad citizen' (Arguedas, 2020). Recent literature has shown the importance of healthism in shaping people's relationships with their bodies. Healthism has had a particularly significant impact in eating disorders. Arguedas (2020) investigated the concept of healthism in relation to Orthorexia

Nervosa, a pathological obsession with healthy food. Arguedas (2020) explored the way in which narratives around this are constructed through pressure on people to adequately diet and exercise in response to the perceived problematic nature of having a fat body. In particular, she explores the influence of the media on constructing these narratives; discussing media narratives surrounding obesity which stress individual responsibility for health and the importance of self-control. These narratives relay that 'fatness' is a problem, and that food and adequate exercise should be used to address it.

In line with this, Courtney discussed the concept of 'health' in relation to food and exercise.

> *Courtney = Healthy means eating right as well, like eating right and just not feeling drained I guess and just being like…mmm…yeah and just not feeling drained and out of energy, and just being able to keep a good hmm…attitude I guess, so plus healthy can also be like you have to think well about things, that's like wellbeing and everything but if its just the physical aspect, just eating right, just feeling right, and having enough exercise*
>
> *INT = And who defines that? How do you know how much…*
>
> *Courtney = There is like the minimum, it tells you like the national and everything but I've like to me, it depends on like what age you are as well but like as long as you at least walk and do like a proper amount of exercise it's fine, it depends um…on the person, because I um also want to be fit as well so that's why I would do more exercise than other people,*

but if you just walk when you get to work and everything I know that's also you can also be fit through that, and healthy through that…

Courtney's description of "eating right" signals that there is a shared knowledge between her and the interviewer of what this means. Her use of the phrase "at least" when discussing the amount of exercise a person should do suggests that she perceives there to be a baseline level of physical movement that we need to do to keep ourselves healthy. If you do this then you will be "fine," insinuating that doing less than this means that you are failing to "take care of yourself properly." This speaks to the expectations placed on us by society, where the concept of health is routinely intertwined with fitness.

This subtheme speaks to the notion of 'healthism' as discussed in the literature review. Neoliberalism argues that good health is available to everyone, associating individual morality with the capacity for self-care, the ability we have to provide for our own needs (Brown, 2006). Policies around our health and wellbeing work to nudge citizens towards acceptance of neoliberal influences (Cromby & Willis, 2014). Petr Skrabanek (1994, p.15) argued that "human activities are divided into approved and disapproved, healthy and unhealthy, prescribed and proscribed, responsible and irresponsible." Participants' expectations of what one should and should not do to stay healthy suggests a sense of one's own 'responsibility' to fall in line with these requirements (Skrabanek, 1994). These extracts suggest the influence of healthism on their perception of what healthy is, speaking not of their own sense of healthy, but of what it means for others to be healthy. As such we can identify the impact of socially constructed norms on their concept of what it means to be healthy.

Reflexive note: It is interesting to note that the two youngest participants arguably put the most emphasis on our responsibility for our own health when compared to the other participants, particularly surrounding diet and exercise. Perhaps this suggests an increasing awareness of children growing up in our modern society of the expectations placed on us to look after our health, and the influence of the media on this. It seems feasible that young people's constant exposure to social media resources such as Instagram and TikTok may heighten this sense of responsibility, as these sites constantly bombard young people with images focused on 'healthy' lifestyle. It is interesting to consider whether this increasing awareness could lead to higher rates of health anxiety in the younger members of our society, who are taught that they are responsible and accountable for their own health, and that in turn, they can control their chances of becoming unwell.

Avoidance

Four of the participants discussed avoiding situations or triggers that they found enhanced their anxiety. Joanna described the impacts of avoiding having a smear test done.

> *I was starting to worry more about having something and not knowing about it than having it done and I was like oh okay well this means I need to go and get it done like yeah. But it was about 3 or 4 months overdue like I really dragged my heels on it (Joanna)*

In this situation, Joanna's avoidance meant that her health fears were actually enhanced. This fits with the cognitive model, which argues that avoidance serves to maintain health-related fears. Three of the participants reported wanting to avoid external information that could be 'triggering' to their health anxiety.

I can just hear something on the radio or see a program on television or somebody can say something, and it just triggers fear. I just go into fear and I get like, you know my heart starts racing and um…and sometimes I can, you know settle it, and other times it can accelerate into you know like a cycle of like real like terror (Lisa)

*…details that like f*** I really don't want to hear and um…that can, I generally start humming to try and block it out, I walk away, um I choose to be away from it (Lisa)*

Lisa goes on to describe how she removes herself from situations where she is exposed to medically related information. She discussed how hard it is when she is often surrounded by elderly people who she finds talk a lot about their health. In response to this she avoids watching medical programs, using? the internet and conversations with friends about health. This extract also shows the amount of distress caused by exposure to these external triggers, causing her to experience "terror." It makes sense therefore, that she would seek to avoid this 'triggering' material in order to prevent this cycle beginning.

Research shows that external triggers are frequently avoided by people with illness concerns. These can be external sources such as media related to illness (e.g., AIDS, cancer; personal stories concerning illness and visiting friends who are ill). The avoidance that she engages in influences her daily functioning, where she is avoiding triggering stimuli that surrounds us in daily life, (e.g., her friends and television programmes). As such, we get a sense of the impact of these avoidance behaviours on her day to day life, and the fear surrounding them should she be exposed to them.

Similar to Lisa, Claire discussed actively avoiding information from external sources.

> *I remember I actually cancelled chrome and safari off my phone because I knew that I would just end up googling symptoms (Claire)*

As discussed in the literature review, Warwick and Salkovskis (1990) argued that exposure to illness-relevant information can trigger episodes of health anxiety in those with a vulnerability to experience health concerns. However, experimental research to support this has been limited with studies showing conflicting results (Lecci & Cohen, 2002; Marcus, 1999). In an experiment using the Stroop Task, participants who evidenced higher levels of bodily sensitivity directed more attention to health-related words than controls, thus making their reaction time slower. This finding suggests that the participants with higher levels of bodily sensitivity are more sensitive to health related information (Lecci & Cohen, 2002).

In a study by Marcus (1999), participants were asked to complete a scrambled-sentence task that included neutral or health related words. However, unlike Lecci and Cohen (2002), their results showed that these words did not appear to make the health anxious participants more anxious than their counterpart controls (Marcus, 1999). As there is limited research exploring this facet of the cognitive model, it is difficult to gauge whether this is a shared experience for people with health anxiety. However, in the present study, three of the participants described actively avoiding external information as they worried that it could trigger their own concerns.

Another participant discussed avoiding information for fear of finding out something about which she might "catastrophize". This participant described avoiding looking at other causes aside from the one she believed she had (DVT).

> *Sarah =like other things that you could get I don't necessarily research because I don't want to end up knowing enough about them to like catastrophize on all of that stuff um…*
>
> *INT = So you kind of avoid information about…*
>
> *Sarah = Yeah like um if I go to the doctor and they tell me something's wrong with me I'll follow their advice but it's better to do that for me then to try and find information on other stuff because it's terrifying, and I'll find a way to think I have it*

It seems that this participant did not want to see any information that she could find potentially triggering for her anxiety. Similar to the earlier extract from Lisa, Sarah employs the use of the word 'terrifying' to suggest the level of distress that external information can cause her. This extract also speaks to a finding by Singh and Brown (2016a). Their study sought to investigate the concept of 'query escalation', referring to searching for information about serious diseases that are possible, yet unlikely, cause of the symptoms that were the original focus in the enquiry. Their results indicated that health anxious individuals were particularly likely to engage in query escalation, and to overestimate the likelihood of material confirming their illness. Singh and Brown (2016a) reported that this behaviour could lead to enhanced checking behaviour, causing health anxious people to begin checking for symptoms that have been identified in that disorder. Sarah evidences some query escalation,

where if she goes ‘off-piste’ of her search, she can find a way to convince herself of a more serious, catastrophic cause for her symptoms.

Summary

This theme of ‘Better Safe than Sorry’ captures a number of shared experiences across participants. Most prominently, it speaks to the concept of intolerance of uncertainty, where participants feel the need to find an answer. As such, participants sought to employ safety-seeking techniques, such as ‘Dr Google’ and body checking to provide them with reassurance one way or the other, in a bid to eliminate the uncertainty they were experiencing. This theme also describes the influence of avoidance behaviours on participants’ functioning, as they attempt to quash the potential for enhanced anxiety. It also speaks to the increasing responsibility placed on individuals to take control of their bodies. In contemporary society individuals are expected to take precautions and follow guidelines to ensure that they remain ‘healthy.’ Failing to do so results in the failing to be a ‘good citizen.’

Theme 5: Vulnerability

In this section, I wish to address a variety of related points collected under the theme of vulnerability. The first of these is 'free-floating worry,' which explores participants' feelings of vulnerability not only to one illness, but to many. The second theme is that of 'projecting' where participants described a sense of vulnerability, not only in their bodies in the present time, but also in the future.

Free-Floating Worry

Most of the participants described their worries not as stagnant but rather as moving from illness concern to illness concern; they were 'free floating'. These participants reported that they had had multiple concerns around a number of illnesses over the years and spoke of how each of these appeared and eventually went away, only to be replaced by a new worry.

> *…it's always constant worry just about different things, it kind of manifests itself in different ways…yeah (Joanna)*

Joanna attributed her "constant worry" to the fear that she might lose her health again. For her, there was no single concern that she worried about, but rather anything that she believed could be a threat to her health. Joanna described being triggered by internal sensations, such as having a headache.

> *…you know like I get a headache and I'm like I've got brain cancer you know, not straight away you know I'm not ridiculous but like if I've got a bit of prolonged headache I do I say stuff to my mum like, maybe I've got brain cancer? (Joanna)*

When Joanna became worried about her health, she often experienced a prolonged physical sensation, which she perhaps recognized to be unusual or abnormal for her. As such, one can get a sense of the vulnerability that this participant experiences daily, with a constant awareness of her own body and its sensations, and an acute awareness of the potential for something to go wrong at any time. It is also apparent that Joanna jumped to the 'worst case scenario' of a potentially deadly illness, brain cancer, being the cause of her illness. This fits with the cognitive model's construction of health anxiety, where people often jump to catastrophic interpretations of their physical symptoms (Marcus et al., 2008), Central to the cognitive model is the concept that people with health anxiety hold more dysfunctional cognitions surrounding illness, which make them more likely to interpret physical sensations as catastrophic, rather than attributing them to a more benign cause (Salkovskis & Warwick, 2001).

Although Sarah described having one worry that seems to be most prominent for her at that moment, deep vein thrombosis (DVT), she also experienced concerns about other potential illnesses.

> *…migraines I'm always like is this a migraine or could this be like...ah I used to always really worry that I was going to have a stroke, again, I am not the kind of person that is ever going to have a stroke. I have never smoked in my life, I know that smoking makes it harder, makes it less likely you'll get a stroke um…and I'm not like an old woman with super high blood pressure, but I…you get a headache and it gets put in one spot and I'm like oh, and I'm reminded that my brain could like burst a blood vessel at any moment um…and that's terrifying, um….but yeah I get, it's*

not just the DVT it's anything that my imagination can kind of pull up, which is really fun, really relaxing (Sarah)

When Sarah described herself being "reminded" that her brain could "burst a blood vessel at any moment" she depicted a sense of vulnerability in her own body, where her body could let her down at any moment. Just in this extract she describes at least three possible illness concerns: a stroke, bursting of a blood vessel in her brain and DVT. As such, we can imagine the sense of vulnerability that Sarah experiences on a daily basis. She comments rationally that she is not "the kind of person that is ever going to have a stroke" but at times she is vulnerable to her own imagination, and sometimes more irrational thoughts. As such, we can see her susceptibility to more rational thoughts at times where she is experiencing heightened anxiety. This gives us a sense of the difficulty that people with health anxiety may have in rationalizing their thoughts when experiencing high anxiety.

Sarah believes that her body could let her down at any moment, either through illness or through her own imagination, which could begin to torment her with a new illness concern. It is interesting that both Joanna and Sarah discuss a somatic cause as the trigger for their worry, and that for both of them this was a headache. Research confirms that internal stimuli are the most common precipitants for episodes of health anxiety (Abramowitz & Braddock, 2008). When viewing this from the cognitive perspective, internal triggers from the various sensations we experience in our bodies makes health anxiety more likely to be 'free floating.' Living in a human body every day comes with a range of sensations, sometimes familiar, sometimes not. As such, constant vigilance and attendance to all of our sensations and the need for an explanation for them would likely prove worrying, and perhaps, as this participant

suggests even, "terrifying." Sarah went on to describe her anxiety around DVT further.

> *…I did a lot of googling on the pill, I found the pros and cons list, and it was like, and the different side effects it could give you and one of them was like a slightly higher chance of DVT other things that the pill can you give you was like you know mood problems, headaches and all kinds of things, but this is the one that I zeroed in on, um…and then ever since then I've been really aware of what DVT is and it sounds horrific to me… (Sarah)*

Although Sarah reported that she has a variety of illness worries, DVT appears to be the one that she "zeroed in on" and the one that has remained consistently worrying over many years.

Sarah = know like the old Catholic school here's the photo of some graphic diseases so you know you won't do any sins or that kind of thing

INT = Do you think that had an influence on you?

Sarah = um…it…I'm not actually that scared of getting an STI

From the extract above we can see that not all health conditions are concerning for people with health anxiety. This begs the question of why some worries might be more troubling than others. Further research into the area of the specific content of health anxious concerns would prove both useful and interesting.

There is a lack of research investigating whether it is more common for people with health anxiety to exhibit concerns about one illness or multiple illnesses. In the present study most of the participants experienced concerns about multiple

illnesses rather than being entirely focused on one. However, their worries are focused on one particular disorder at a time, and when that worry is resolved another one may take its place.

Projecting

Four participants reported concerns about the future, and what might happen to them if they became ill. Research has found that it is common for people with illness concerns to worry about medical problems that will not manifest until sometime in the future (Abramowitz & Braddock, 2008). For example, they might be scared that getting sunburnt might mean that they will develop skin cancer at some point in the future. As such, people with these beliefs can never obtain certainty about their health because no one can provide them with certainty about the future (Abramowitz & Braddock, 2008). They therefore start to engage in behaviours that they believe reduce their risk of this in the future, such as staying out of the sun or reading research around skin cancer on the internet (Abramowitz & Braddock, 2008).

In most of these cases, future concerns were almost always about the 'worst-case scenario.' Diane detailed her concerns that she might become sick with a debilitating illness on top of the physical symptoms she was already experiencing.

> *Well I'm 54 now and I think oh my god if this goes on for the rest of my life and I get sick with something else, my mum had dementia my dad had Motor Neurone disease so I'm thinking, if I, what if I'm still young-ish and get something else how am I going to cope (Diane)*

Diane's concerns that she would be unable to cope fall in line with the cognitive behavioural paradigm of health anxiety, which suggests that those with

health anxiety often exhibit beliefs centred around not being able to cope with illness or death (Asmundson et al., 2001).

Lisa also discussed her concerns about the future.

> *I mean sometimes it can get quite bad, sometimes it's not too bad, sometimes it can go into projecting into the future, of how this is going to be and um…you know like what's going to happen to me, and what's going to happen to (husband's name) and like how it's going to be and that kind of stuff (Lisa)*

Claire also reported ruminating about the future. Similar to Lisa, she discusses the impact on her but also on her partner, should she become ill. As such, we can see that anxiety is likely escalated in this situation, as she appears to begin to catastrophise about the impact on her husband. She went on to discuss how she can convince herself "100%" that she has a disease that will eventually kill her.

> *I'm not one that's prone to depression, but I get so depressed…because I start treating every moment with the girls like it's my last, like I start thinking oh my goodness I'm terminal and I'm never going to get checked out, because…(deep breath)…you know like or I'll think that eventually when I do choose to go and get checked out they'll tell me I've got three weeks to live or something and I get so consumed and so….(Claire)*

In these situations, she manages to convince herself not only that she is unwell, but that the illness she has is the 'worst case scenario' where she will be told that she will be terminal, and that she only has limited time left. This gives an insight into how "consumed" she is by this feeling, and how this must affect her life. She

reported that when she feels like this she never wants to leave her children, and just wants to be at home with them. As such, we can see the impact that this has on her lifestyle, not only on her levels of distress when facing this 'terminal illness' but also on her ability to function, as she begins to withdraw from social situations. For Claire, these thoughts were always the worst case scenario.

> *there was no grey area, never ever a grey area that I always felt like I'm going to get brain cancer and I'm going to die, there was never this image of me going through chemo and surviving, anything like that…never…it was always, the kids will have Leukemia and we'll find out and they'd die (Claire)*

She recalled her experience of seeing herself suffering from a terminal disease or seeing herself being told that her children have Leukemia.

Research has shown that intrusive imagery is a prominent feature of other anxiety disorders such as OCD and PTSD and has been implicated in the maintenance of these anxiety disorders (Hirsch & Holmes, 2007) . Research indicates that people respond to these intrusive images by engaging in behaviours such as avoidance and rumination (Muse et al., 2010). However, only a few studies thus far have explored imagery in people with health anxiety. A study by Muse et al. (2010) reported that 78% of their participants with DSM-IV experienced recurrent, distressing and intrusive imagery. It is important to recognize that this study's participants were taken from a community sample, so this prevalence does not necessarily translate to clinical populations. However, Muse et al. (2010) found four key themes associated with imagery. These were i) being told the bad news that you could have a serious illness, ii) suffering from a serious or life threatening illness, iii) death and dying due to

illness, and iv) impact of own death or serious illness on loved ones. 86% of their participants classified their images as relating to the future. The present study's participant's concerns were also future focused through her use of language such as "I'm going to get" and "the kids will." Claire also had the experience of imagining herself suffering from a serious illness and dying. However, prior research does not account for the imagery she had of her children suffering from a disease and her being told about it. One would expect that this imagery would facilitate maintenance of her checking behaviours of her daughter, but further research in the area of imagery in health anxiety, and imagery in health anxiety by proxy is needed.

Reflexive note: It is feasible that the other participants in the present study also experienced imagery as part of their concerns. However, research suggests that people with anxiety often fail to describe imagery unless directly asked about it (Hirsch & Holmes, 2007). In this study I did not ask around this, therefore more people in this group may see imagery as part of their illness experience.

Summary

This theme of vulnerability speaks to the inherent sense of susceptibility that these participants experience in both their present and future bodies. Vulnerability around their future health meant that some participants attempted to take precautions to ensure the health of their body in the future. This was intended to give them a sense of control over the uncertainty of the future. However, this certainty of good health of course, can never be achieved. For most of these participants, health anxiety is free-floating, moving from illness to illness. They described a constant sense of unease, given a persistent awareness and negative interpretation of their bodies and its associated sensations.

Theme 6: Therapy

This theme explores participant's experiences of therapy and is comprised of three subthemes. The first is 'last resort', which speaks to the shared experience of a number of participants who found that therapy was the last intervention recommended or provided to them. The second, 'validation', reflects participants' experiences of feeling heard and listened to within the therapeutic space, whilst 'self-healing' explores the participants' own journeys of managing their concerns.

Last Resort

Many of the participants described being told by health professionals that their experience was 'anxiety' related. However, this was rarely followed up by doctors nor was the concept itself explained to them. As a result of this, therapy was the 'last resort' for many of the participants, an option that was only suggested to them after a substantial amount of interaction with health care providers.

> *…And then I ended up in respite yeah. Finally then my Doctor put me under the mental health team but this was now three months later, all of it should have happened three months earlier. To…to a point of preventing it all, so I was now three months into it and yeah had to go under the mental health team and see a psychiatrist, but she should have done it, every week when I kept going back she knew she kept saying it will be fine, she kept saying to me you're not going to die from this, and I kept saying I'm not worried about dying from this I'm worried about living through it (Diane)*

From this extract, being referred to a mental health team was one of the last processes that happened in this participant's help seeking journey. Her use of the word "finally" reflects a belief that she should have been referred to mental health support a long time before she was. For this participant, the effect of her health anxiety on her functioning was so severe, that she worried about "living through it." It is of interest that this participant did not report that the doctor had concerns around her physical health, repeatedly telling her "you're going to be fine." This raises questions as to why the doctor did not suggest a potential psychological reason for this problem and, if they did, why no referral was made. This again reflects the idea that a patient is considered "fine" if their symptoms are psychological rather than physical.

Joanna felt that her mental health concerns were dismissed when she was in hospital. She describes having to seek out her own psychological care following the trauma of her illness.

INT = Yeah how did you find that experience with the hospital and…

Joanna = They just don't really talk about it, they just don't really

INT= You're talking about your mental health?

Joanna = Yeah they don't really…they…that's not really set up for it so… I had to kind of seek out a lot of stuff myself, and also like a psychologist…

From this extract, we can see that this participant experienced the hospital being a context dominated by focus on the physical body, where she experienced that her psychological concerns, even though perhaps resulting from physical trauma,

were dismissed. As such, we can see a perceived differentiation between body and mind. These are understood as two distinct entities which must be treated by different professionals in different spaces. This differentiation has been conceptualised under Cartesian dualism, where mind and body were conceptualised as radically distinct. Traditional biomedical models of symptoms have often fostered this dualism in their conception of disorders, including the DSM (Walker, 2019). However, the DSM5 saw a move away from this distinction, with research moving beyond traditional mind-body dualism working to conceptualize disorders within their psychological, biological and social context (Walker, 2019). As such, we can see the importance of the social constructionist framework in exploring these narratives, by providing us with an underpinning through which we can explore experience in its wider context.

In line with this, Claire had also been battling with anxiety surrounding her health for many years before she was able to access mental health services and eventually see a psychotherapist.

> *I was seeing a psychotherapist, I've only stopped seeing him last month, but I had seen him since November last year, and before that I had 14 weeks through the community mental health, I guess the public systems, so the fourteen weeks was all free and that was quite good, because that was the first time that I had had proper therapy (Claire)*

Claire described waiting a long time to access psychological support through the public health system. It also remains unclear whether her referral to a community mental health service was motivated by her hypochondriacal concerns, or whether she was referred as a result of concerns around her having postnatal depression. Therefore, the question is raised as to whether one is likely to be referred for 'pure'

health anxiety, or whether people experiencing health anxiety are the ones often left floating between the physical and mental health sectors. Despite her long wait, she described the benefits of engaging with mental health professionals.

> *Claire= …I feel very lucky and you know, I don't know I know our mental health systems gets a really bad rap but I'm, I've only experienced the best.*
>
> *INT = That's good, yeah*
>
> *Claire = I really think we are so, well maybe its this DHB, but --- has been fantastic*
>
> *INT = Oh it must be --- yeah…*
>
> *Claire = They are great*
>
> *INT= Yeah are they?*
>
> *Claire = they are great. Like when I had postnatal depression and anxiety after (baby name), I went into respite, they put me on medication, I was there for three weeks until my depression and anxiety kind of…lifted a little bit um…and they gave me like a home carer for four hours a day, four times a week for two months until I could function alone with a baby*

Claire experienced postnatal depression following the birth of her daughter and it appears that mental health services were provided reasonably rapidly to this participant, and at a high dosage. Perhaps this is reflective of the risks surrounding PND with a newborn, or the level of difficulty she was experiencing. However, it

presents a stark contrast with previous participant's long waits to be offered therapy for their health anxiety, perhaps reflecting some residual stigma surrounding this disorder in comparison to others.

Research investigating experiences of health anxiety from the doctor's perspective reflects difficulty in shifting patient's perspectives to the psychological due to the patient's common resistance in believing that this problem is physical not psychological (Holder-Perkins et al., 2000). Doctors report being apprehensive when suggesting a psychological influence behind symptoms. They report that they are fearful of making their patients feel stigmatised or invalidated. Therefore, although aware that this may be health anxiety, doctors often avoid making the diagnostic switch to psychosocial issues. This difficulty is further compounded by the limited time available in primary care consultations (Holder-Perkins et al., 2000).

Validation

A number of participants reported benefitting from understanding the psychological perspective of their difficulties. A couple of participants talked about the benefits of seeing a therapist.

> *Diane = so with the psychologist saying yes you do, you just really need to train your body or your brain to not react, 'cos your, the only reason your body is reacting is because your brain has told it to because it thinks that it needs to be afraid of something, so its warning you, it's a warning signal saying, you need to run you need to get out of this situation 'danger danger.'*
>
> *INT = so it kind of gave you that sense of control back?*

Diane = It did because he said that's when, so you do these techniques so that you retrain your brain, so that it doesn't need to be in danger, or telling you that there's danger all the time when there's no danger.

For Diane, being given an understanding of how her brain and body were interacting gave her a sense of control, coming from externalizing this experience to the biological mechanism of fight or flight. This speaks to the experience of participants who were repeatedly told that they were experiencing anxiety, with no explanation of how this functions and suggests the benefits of explaining the psychological mechanism behind anxiety to patients.

For a number of the participants having someone listen to them and to help them to understand what might be going on for them proved invaluable.

Claire = and I think, it was more, it was very much like my key worker and the doctor at community mental health who have been able to actually pinpoint exactly what I need to remain well, and for me I tend to find my triggers, because I never even knew about triggers but I have plenty (laughs)

INT = Yeah

Claire = and being able to reduce those triggers has been very life-changing I think

For Claire, a model through which she could understand the 'triggers' of her anxiety proved to be extremely helpful. In line with this, studies have indicated the benefits of psychoeducation in reducing hypochondriacal concerns (Barsky et al., 1988; Bouman, 2002). Research indicates that psychoeducation seems to benefit from

a model to which they can attach their complaints and thereby place them in a different context (Buwalda et al., 2007).

Joanna discussed her experience with Dialectical Behavioural Therapy (DBT).

> *Joanna = I really think DBT was the key to turning me around like it's really helped me a lot*
>
> *INT = It's really good that you found that*
>
> *Joanna = Yeah I reckon I would have been fired by now because I was just not coping at work, and you know I was just crying all the time and, it was a waste, like what are you paying me for to cry? You know, it was stupid, I didn't want to be that person but I didn't know how else not to be. So yeah DBT gave me those skills so…I am really grateful for it*

Joanna reflects on the significant impact of her health on her ability to cope at work. Like Claire who described therapy as "life-changing", Joanna also reflects on the significance of DBT in helping her. In particular, she found the group environment of the DBT therapy to be particularly beneficial.

> *Amazing. I just think it's the most amazing thing ever, I'm part of a really excellent group, my psychologist facilitates it and she's amazing amazing and um…it's just a really great group and people share quite openly and really struggle with similar and very different things and…(Joanna)*

There has been little research on the effectiveness of DBT for treating health anxiety. It should be noted that this participant also deals with comorbid mental health problems to her health anxiety, so it is possible that the DBT group was not targeted

at her health anxiety. Although there is limited research for DBT for treating health anxiety, research has indicated the effectiveness of group CBT, but the amount of empirical support is limited (Weck et al., 2015). There are few studies that have assessed the effectiveness of group therapy for health anxiety, with two of the studies having less than ten participants (Avia et al., 1996; Bouman, 2002; Hedman et al., 2010; Stern & Fernandez, 1991; Weck et al., 2015).

Eilenberg et al. (2013) found that using Acceptance and Commitment Therapy (ACT) for patients with severe health anxiety was effective in reducing their health anxiety, as well as their somatic symptoms and emotional distress. They found that these improvements were maintained at six month follow up (Eilenberg et al., 2013) Therefore, this research points to group therapy as an efficacious and cost-effective option for treating health anxiety at both clinical and subclinical levels.

All of the participants who had accessed therapy relayed a positive experience and spoke of its impact on their ability to understand the symptoms they were experiencing.

> *Yes exactly. So I've been doing therapy um with a psychotherapist for the last year. I have recently just stopped…um…and that's really helped. I guess for me…cause a lot of the time I wondered is it, yeah exactly, just me being irrational, me being anxious or is it something worth worrying about (Claire)*

Therapy allowed Claire to understand the role of anxiety in her cognitions, where some thoughts may be irrational and others perhaps completely viable. Diane also described the impact of accessing psychological support in helping her to make sense of her experience.

Diane = Yeah and yeah you don't know and then you go to a doctor and they keep saying its anxiety and I'm like but I don't get it, I'm not even anxious

INT = you just need someone to explain it

Diane = Yeah I needed someone to explain how the body works, and it was a psychologist that did that for me

As discussed earlier, research has found that those with chronic-care seeking behaviour are often dismissed and avoided by health care professionals (Rapport et al., 2018). It is feasible that this participant's repeated visits to her doctor led to quicker dismissal of her concerns, and limitations on the amount of time spent explaining her anxiety to her. Her interactions with her psychologist gave her a sense of being heard, and time being taken to validate and explain her experience to her.

'Self Healing'

A number of the participants discussed techniques they used to reduce their symptoms. In some cases these were taught to them by a therapist, and in others these were initiated independently. A couple of the participants talked about the benefits of physical exercise as a means to reduce their symptoms.

I get into action, it really helps me to do physical stuff, to exercise, I walk a lot, to do something like gardening or like hard physical labour is hugely useful (Lisa)

Going to the gym, I used to wake myself up at 5:30 every morning and go for you know an hour and a half and start myself off like that. And that is

when…the times when I've been able to do that is when I'm most mentally well (Claire)

There is a substantial amount of research supporting the positive influence of regular exercise on anxiety symptoms. However, the relationship between health anxiety and physical exercise has had minimal investigation (Pugh & Hadjistavropoulos, 2011). Some research has indicated a potential relationship with hypochondriacal symptoms and exercise dependence. One study found that 28% of people attending a fitness facility met criteria for both hypochondriasis and exercise dependence (Lejoyeux et al., 2008). These results imply that people with hypochondriacal worries may be more likely to be more inclined to exercise and to experience more withdrawal symptoms if they are unable to exercise (Pugh & Hadjistavropoulos, 2011). Consequently, this suggests that we should be mindful of this when encouraging clients to use exercise as a means to manage their symptoms.

A couple of the participants reported using mindfulness skills to calm their anxiety.

So then I do you know I call it praying, but I do self-healing, so I like um talk to my body and like tell it what to do, and I like send it healing and I like…say to the, I try to say to the fear that I release it you know so I can do like mantras almost like where I repeat it, it's almost a way of like blocking it……I have certain things that I do when I'm going into stressful situations like having an MRI and I did them all to try and kind of calm myself, and I meditated in the waiting room and I did, I did all those things it wasn't easy, but it was acceptable. It was possible I guess (Joanna)

Recent research has demonstrated the efficacy of incorporating mindfulness techniques into treatment for health anxiety (Luberto et al., 2017). Mindfulness assists individuals with health anxiety to be more accepting of physical sensations and emotional distress, helping them to prevent the catastrophic misinterpretation of these symptoms which often shapes the cycle of health anxiety (O'Bryan et al., 2018). Two of the participants discussed the benefits they had experienced from using sensory modulation.

> *…on the way home I could feel this heat starting to rise up again so what you do is you start, (demonstrates) so I was feeling the side of the chair and putting my feet on the ground, so I had some chewing gum with me so it's about taste as well, so it all takes you away from the anxiety, and say looking around and going I'm just driving in the car, I'm here with my family, it's safe, it's all normal and that's the retraining of the brain not to react…(Diane)*

Another participant had a pair of socks that she would wear to give her a sense of safety.

> *Do you know what I really like about it my psych…in DBT and my psychologist has talked to me about stress balls and different sort of things to play with and stuff. But I like to be invisible with it, if I can, and the socks are completely invisible. Nobody has to know apart from me, and well my four and a half year old knows, it's like my little secret, our little secret and…(Joanna)*

Sensory modulation is becoming increasingly common in mental health services in New Zealand. This refers to using the senses to reduce manage and change

emotional states. A study on the use of sensory modulation in community mental health settings relayed the benefits of sensory modulation on improving self-management and self-awareness in its participants (Wallis et al., 2018). However, there is little evidence looking explicitly around the benefits of sensory modulation for those with hypochondriacal concerns. It was interesting to hear the benefits of sensory modulation for these clients. In sensory modulation, one pays a lot of attention to one's physical sensory experiences. For the participants quoted above this experience is described as calming. However, the evidence suggests that paying a lot of attention to physical sensations associated with their anxiety can often prove to be more distressing. As such, further research into sensory modulation for health anxiety would prove valuable.

Summary

There is a lack of prior research investigating the lived experience of people who suffer from health anxiety with therapy. This study highlights a number of positive experiences for people who worry about their health with therapy. It demonstrates the importance of further exploration of the role that therapy can play in the wellbeing for those suffering with concerns around their health. The findings evidence the need for increased awareness of the presentation of health anxiety within our health services as well as continued work to provide more access to psychological support. These participants were often told that the experience they were having was anxiety related, but there was little explanation given of how this was working, or what the next steps might be to treat it. Participants often were only referred to therapy when their level of distress became exceptionally high. Consequently, for a number of our participants. therapy was seen as the last resort. However, the findings suggest

the benefits of therapy in supporting them, indicating the need for therapy to be considered earlier on.

Reflexive note: For this theme I thought it was important to briefly reflect on some of the underlying concerns that I had. I do question whether my role as a training clinical psychologist influenced their accounts of their therapy experiences at all. It is possible that they were mindful of what they said regarding this, or perhaps overly positive in order to avoid causing me any offence, or perhaps to avoid fears of being challenged by me around this.

CHAPTER 8: LIMITATIONS AND CONCLUSIONS

This research study asked what it is like to live with experiences of health worry, and how people experience and manage these worries. These questions can be considered in regard to the findings from participant interviews. This chapter will outline the key conclusions of the research as well as its clinical implications and recommendations for future research. This will be followed by an outline of the limitations of the study.

The participants shared complexities in their narratives of health anxiety. Their experiences of anxiety surrounding their health were fluid, with anxiety fluctuating and the content of these anxieties changeable. The Participants' experiences of health worries were also greatly influenced by relationships with family, professionals and themselves. Throughout the findings it is clear that the influence of relationships dominates, suggesting the need for greater integration of interpersonal factors when exploring experiences of health anxiety. When analysing the findings, it became clear that a number of the themes could have been bracketed under the first theme of 'relationships.' For example, two themes of invalidation and insight both incorporate interpersonal relationships in their narratives.

In particular, difficulties in relationships with health professionals played a dominant role in participant narratives. Patients remain tangled in a medical sphere crafted through power differentials, leaving them experiencing a lack of autonomy in regard to their care and ensuing anxiety as a result of this. These participants ask to be heard and be given more autonomy over their own bodies, calling for a more

collaborative interaction between patient and doctor. Overall, participants reported largely negative attitudes towards health professionals, identifying experiences of invalidation and poor communication. Through these experiences we can see the importance of the role of the health professional at the onset and in the course of health anxiety, speaking to an integral need for clinicians to develop a trusting and communicative relationship with their health anxious patient. Overall, participants needed to feel validated and heard by their doctor Failures in this led to increased feelings of unease and mistrust towards clinicians.

Participants who reflected on their lived experience may have gained additional insight into their difficulties. Their interactions with health professionals provide useful information for future research or a basis for health practitioners to reflect and learn from their own interactions with people with these difficulties.

On a number of occasions many of the participants had been told that their physical experience of symptoms was, in fact, a psychological experience. However, for the most part, further explanation around this was not provided. Subsequently, participants were left feeling invalidated in their experience and unsure of where they could access support. This sense of uncertainty makes it more likely that participants will access primary health care services as a means to access support, rather than mental health services. This is of great concern when considering the impact of health anxiety on medical services.

Clinicians should continue to be educated around early detection and awareness of health anxiety, as well as on their important role in shaping the prognosis of health anxiety. A number of the participants reported numerous interactions with primary care physicians. It appears that this is an area where

attempts could be made to bridge the noticeable gap between mental and physical health. Accordingly, it is suggested that clinicians attempt to provide psychoeducation either within session or through resources that the patient can access at their convenience, such as online CBT workbooks. Without some explanation of what they are experiencing, it is likely that patients will continue to return to medical services rather than accessing psychological support. However, it is also acknowledged that many patients will be unwilling to engage with the psychological explanation of their disorder. Therefore providing these patients with knowledge around what they might be experiencing will serve to help increase insight in this area. In line with this, further research into community or online psychoeducation groups for health anxiety is recommended. This research reflects the benefits of patients feeling like they are being listened to, as well as learning that their experience is a shared one.

All of the participants used the internet to look for health-related information. This finding supports previous research in this field that has demonstrated the importance of the internet in shaping and maintaining experiences of health anxiety (Singh 2015; Singh & Brown, 2016a; Beckett, 2009). A number of the participants accessed the internet prior to their doctor's appointment and some reported discussing this content with their doctors. This represents a marked change from times prior to the internet, where the clinician was most commonly the first port of call. As such, this emerging technology and our increasing reliance on it will inevitably challenge and change traditional doctor/patient roles where illness, and control over it, is isolated from the patient (Koeck, 2014).

This finding reflects the growing literature surrounding the concept of 'informed choice' in doctor/patient interactions (Henwood et al., 2003). The prominent dialogue in this area surrounds the patient's right for information surrounding their care (Henwood et al., 2003). This research speaks to increasing support for a collaborative process in doctor/patient process, equalising the power dynamic and sharing control (Koeck, 2014). However, research diverges around the meaning of 'empowering' patients, and whether the internet itself is a tool to do this (Broom, 2005).

In this study, it appears that empowerment for participants meant them gaining some autonomy over their own bodies. However, as has been identified in previous research, there are limits to the ability for patients to address their internet findings with doctors, particularly when the doctor feels like their expertise is being challenged, or professional opinion and 'lay' opinion do not match up (Henwood et al., 2005). Thus, the outcome of this information sharing is still controlled by the way that it is received by the health professional (Henwood et al., 2005). Further research is needed to design a way for a more equal exchange of knowledge in these scenarios. New Zealand has worked to increasingly provide health information that is available online, offered through sites such as the Ministry of Health. However, this raises questions surrounding whether this information is offered to provide us with more autonomy, or does it in fact reflect neo-liberal principals of 'healthism' and being a good biological citizen (Rose, 2007).

Limitations

There are some important limitations of this research to be discussed. The present study only included one male participant, whilst the rest of the participants

were female. Research suggests that in general women report more somatic symptoms compared to men and appear to have a lower threshold for seeking medical consultation when compared to men (Barsky, 2001). Perhaps this is due to societal expectations placed on men. Social expectations often suggest that men should be 'stronger' in terms of handling physical pain, or in reporting it. Furthermore, when examining literature, it reveals that women often indicate higher general levels of worry than men (Ginsberg, 2004). In addition, research has suggested that women are higher in levels of reassurance seeking than men (MacSwain et al., 2009). It is likely that for the present study as evidenced by the findings, the research likely provided some means of reassurance seeking to participants, perhaps making it seem more attractive to female clients. This adds to other research which suggests that women are more likely to involve others in their coping, when compared to men. Tamres et al. (2002) suggested that comparatively, men are more likely to make use of independent coping mechanisms. This is likely due to gender socialization where women are expected to involve others in their coping, whereas men are discouraged from sharing their feelings with others (Tamres et al., 2002).

Within this methodology participants were asked to reflect on the lived experience of health anxiety. Personal experience is notoriously difficult to communicate in a way that reflects its richness, with many aspects of experience often difficult to articulate verbally (Todres, 2007). The implications of impression management should also be raised. This seems particularly likely for those who want to communicate their experience as a physical one, who are resentful of viewing their difficulties as psychologically related. However, the majority of participants were able to reflect on both the psychological and physical elements of their experience Therefore, the implications of impression management are likely limited.

The use of multiple terms to explore this phenomenon was a limitation of this study. This study used terms such as 'excessive worries', 'hypochondriasis' and 'health anxiety.' This was intended to fairly represent the available literature in this field, as well as the participants whose experiences were explored. It is feasible that asking participants around terminology may have helped to alleviate this, but the changing diagnostic labels make it probable that this issue would have remained unanswered.

This study used a self-identified population, and self-selection samples are fundamentally non-representative. Therefore, limitations of self-selection bias are apparent. For example, the participants in this study may show more distress, or are those who feel comfortable talking about their difficulties. This may mean we miss the diversity of experience. The use of self-identification means that these findings are also not generalisable to a clinical population.

Overall, this sample was comprised mostly of New Zealand European participants. This study had no participants from a Maori or Pasifika background, though these are two ethnic groups over-represented in mental health statistics. Future studies with a less ethnically homogenous sample would prove valuable to providing a more valid insight into the experiences of health anxiety within New Zealand.

It is important to acknowledge the tension between social constructionist and positivist discourses that runs throughout this piece. Attempting to explore this phenomenon through a social constructionist lens had its challenges. Much of the previous literature used positivist frameworks wherein the boundaries of 'disease' are assumed to be clearly distinguishable. The tension between these two discourses is

noticeable throughout, especially with discussion of the diagnostic lens often dominating much of the narrative.

However, this tension also appears to be mirrored in the narratives of those experiencing health anxiety. The participants' narratives were all influenced by the discourses of certainty and external expertise. For people with health anxiety, their experiences often do not fit within the boundaries of certainty, with many failing to present with symptoms considered to qualify as a 'real' disease. They are therefore left struggling to make sense of their experience outside of the dominant positivist epistemology and the discourses and practices that align with this. Those with health anxiety are often stigmatised and ostracised through such a positivist framework that continues to shape our medicalised understandings of disease. It can be argued that to understand health anxiety, we must acknowledge this tension, and the implications it has for those whose experience exceeds the taxonomies and procedures of medical expertise.

Upon reflection, the language used in this thesis is often (post)positivist in nature (i.e., reflecting an emphasis on objectivity and determining causality) rather than being social constructionist (i.e., reflecting on how language and context produces knowledges and subject positions). This shift in paradigm detracted from further analysis of how participants and the researcher came to craft their understandings within the larger sociocultural context. Ironically, it is possible that the researcher's own context influenced this deviation from social constructionist underpinnings. Alongside this research project, the researcher was also studying to be a clinical psychologist. This involves a dominant focus on learning and understanding diagnostic criteria as outlined in the DSM, meaning an exclusive focus

on objectively identifying symptoms and providing causally based formulations. It is therefore likely that this clinical focus diluted the social constructionist narrative of this project, shaping some of the questions and interpretations along more positivist lines. This can be seen in a number of places, including the absence of discussion regarding the co-construction of the relational dynamic between the health care provider and the patient. Further consideration could have been given to the influence of the participants in co-constructing the challenges emerging in the relationship with the health care providers. How the health care provider's own context influenced their relationship with the health anxious person could also have been further explored, for example, the influence of their training in managing patients who are believed to be presenting with health anxiety. Finally, there could have been further exploration of how a parallel process may have played out between participants and the interviewer. For example, exploring how the relationship between participant and interviewer may have paralleled that with the health professional, where they may have been looking to the researcher for reassurance or validation. Further consideration could have also been given to how this relationship may have differed, for example with the interviewer not being involved as a helping professional.

Directions for Future Research

It is of note that one of the younger participants discussed the role of social media on their health anxiety. Social media sites such as Instagram are inundated with content regarding health and wellness. It is anticipated that this increased bodily awareness presented on our screens on a daily basis may be leading to heightened levels of health anxiety within the younger generations, therefore further research in this area could prove beneficial. In line with this, the present study only included

participants 18 years and older. However, the current findings imply the possibility that health anxiety is occurring in this developmental stage, and accordingly, future research using adolescents to extend findings would prove beneficial.

Participants reflected on the benefits of therapy and, as suggested by emerging literature, it is necessary that treatment protocols for supporting those with anxiety surrounding their health continue to be piloted and assessed. Different formats for treatment delivery should be considered such as primary health psychoeducation, community groups and one to one professional support. It is also recommended that different treatment protocols continue to be explored as a means to develop understanding of the most effective treatment method, whilst keeping in mind the idiosyncrasy of individual experience.

At the time of writing, the world is experiencing a global pandemic, COVID-19. People in the community are expected to exhibit heightened vigilance over their bodies, checking themselves and others for symptoms that could reflect possible COVID-19. We are asked to monitor our own bodies in the pursuit of being 'good' citizens, contributing to the safety of society. As a result of its recent onset, there is limited academic research exploring this phenomenon from an anxiety perspective. However, it is evident that numerous health association websites are providing resources to help support people's mental health during this time. It therefore seems likely that this increased surveillance over bodies and personal and/or vicarious experiences of illness related to this pandemic will lead, or has already led to, heightened levels of health anxiety within the community. Consequently, research into the impact of this pandemic on health anxiety is recommended.

This study focused on a community population experiencing health anxiety, diverging from the primarily clinical focus on this disorder. It would be interesting to compare the lived experience of those with clinical levels of health anxiety and community volunteers. Thus, it is recommended that both clinical and non-clinical samples be compared so that the qualitative/quantitative differences between these two groups can be explored.

This study has demonstrated the benefits of therapy in the experience of health anxiety. It provides a place where participants felt heard and validated in their experiences. However, it was evident that this support was often suggested or provided to participants as a last resort. Despite this, clinicians often quickly conceptualise their problems as anxiety, giving it psychological meaning without providing the necessary tools for support. Thus, further research into the experiences of health professionals with health anxious patients is required. In particular research would benefit from a focus on current treatment pathways, particularly in primary care and emergency departments where health anxiety is often encountered.

This study supports previous research indicating that mental health anxiety is a form of health anxiety (Commons et al., 2016). As such, it is suggested that both quantitative and qualitative research should be conducted to explore this area. At present, mental health anxiety does not feature in the DSM-5 descriptors of illness anxiety disorder and somatic symptom disorder. Therefore, further research needs to be conducted to establish whether these criteria need to be reviewed. This would also be important information for establishing effective treatments for those who experience mental health anxiety.

Final Statement

Worrying about one's health is a complex and idiosyncratic experience. This research recognises how experiences of health anxiety are constructed through political and social interactions, and experiences of trauma, power and stigma. The current study argues that health professionals play a vital role in shaping experiences of health anxiety. It is hoped that this research provides pause for reflection for clinicians dealing with health anxiety, and demonstrates the need for clearer treatment protocols and more collaborative care. It is also hoped that the current research provides support for those suffering with health anxiety in seeing shared experience, as well as stories of progress and improved management of difficulties associated with health anxiety.

REFERENCES

Abramowitz, J. S. (2008). New Directions in Health Anxiety: Introduction to the Special Issue. *Journal of Cognitive Psychotherapy*, *22*(2), 83–86. https://doi.org/10.1891/0889-8391.22.2.83

Abramowitz, J. S., & Braddock, A. E. (2006). Hypochondriasis: Conceptualization, Treatment, and Relationship to Obsessive-Compulsive Disorder. *Psychiatric Clinics of North America*, *29*(2), 503–519. https://doi.org/10.1016/j.psc.2006.02.008

Abramowitz, J. S., & Braddock, A. E. (2008). *Psychological treatment of health anxiety and hypochondriasis: A biopsychosocial approach* (Albany 616.8525 Abr). Toronto : Hogrefe, c2008.

Alberts, N. M., & Hadjistavropoulos, H. D. (2014). Parental illness, attachment dimensions, and health beliefs: Testing the cognitive-behavioural and interpersonal models of health anxiety. *Anxiety, Stress, & Coping*, *27*(2), 216–228. https://doi.org/10.1080/10615806.2013.835401

Almalki, M., Al-Tawayjri, I., Al-Anazi, A., Mahmoud, S., & Al-Mohrej, A. (2016, May 25). *A Recommendation for the Management of Illness Anxiety Disorder Patients Abusing the Health Care System* [Case Report]. Case Reports in Psychiatry; Hindawi. https://doi.org/10.1155/2016/6073598

American Psychiatric Association. (1968). *Diagnostic and Statistical Manual of Mental Disorders* (Second Edition).

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5)*. American Psychiatric Publishing.

Anagnostopoulos, F., & Botse, T. (2016). Exploring the Role of Neuroticism and Insecure Attachment in Health Anxiety, Safety-Seeking Behavior Engagement, and Medical Services Utilization: A Study Based on an Extended Interpersonal Model of Health Anxiety. *SAGE Open*, *6*(2), 215824401665364. https://doi.org/10.1177/2158244016653641

Arguedas, A. A. (2020). "Can naughty be healthy?": Healthism and its discontents in news coverage of orthorexia nervosa. *Social Science & Medicine*, *246*, 112784. https://doi.org/10.1016/j.socscimed.2020.112784

Asmundson, G. J. G., Taylor, S., & Cox, B. J. (2001). *Health Anxiety: Clinical and Research Perspectives on Hypochondriasis and Related Conditions*. Wiley.

Avia, M. D., Ruiz, M. A., Olivares, M. E., Crespo, M., Guisado, A. B., Sánchez, A., & Varela, A. (1996). The meaning of psychological symptoms: Effectiveness of a group intervention with hypochondriacal patients. *Behaviour Research and Therapy*, *34*(1), 23–31. https://doi.org/10.1016/0005-7967(95)00052-Y

Axelsson, E., & Hedman-Lagerlöf, E. (2019). Cognitive behavior therapy for health anxiety: Systematic review and meta-analysis of clinical efficacy and health economic outcomes. *Expert Review of Pharmacoeconomics & Outcomes Research*, *19*(6), 663–676. https://doi.org/10.1080/14737167.2019.1703182

Ayo, N. (2012). Understanding health promotion in a neoliberal climate and the making of health conscious citizens. *Critical Public Health*, *22*(1), 99–105. https://doi.org/10.1080/09581596.2010.520692

Bailer, J., Kerstner, T., Witthöft, M., Diener, C., Mier, D., & Rist, F. (2016). Health anxiety and hypochondriasis in the light of DSM-5. *Anxiety, Stress & Coping*, *29*(2), 219–239.

Barsky, A. J., Wool, C., Barnett, M. C., & Cleary, P. D. (1994). Histories of childhood trauma in adult hypochondriacal patients. *The American Journal of Psychiatry*, *151*(3), 397–401. https://doi.org/10.1176/ajp.151.3.397

Barsky, Arthur J., & Ahern, D. K. (2004). Cognitive Behavior Therapy for Hypochondriasis: A Randomized Controlled Trial. *JAMA*, *291*(12), 1464–1470. https://doi.org/10.1001/jama.291.12.1464

Barsky, Arthur J., Geringer, E., & Wool, C. A. (1988). A cognitive-educational treatment for hypochondriasis. *General Hospital Psychiatry*, *10*(5), 322–327. https://doi.org/10.1016/0163-8343(88)90003-5

Barsky, Arthur J, Peekna, H. M., & Borus, J. F. (2001). Somatic Symptom Reporting in Women and Men. *Journal of General Internal Medicine*, *16*(4), 266–275. https://doi.org/10.1046/j.1525-1497.2001.00229.x

Barsky, Arthur J., Wyshak, G., Latham, K. S., & Klerman, G. L. (1991). Hypochondriacal patients, their physicians, and their medical care. *Journal of General Internal Medicine*, *6*(5), 413–419. https://doi.org/10.1007/BF02598162

Bass, C., & Murphy, M. (1995). Somatoform and personality disorders: Syndromal comorbidity and overlapping developmental pathways. *Journal of Psychosomatic Research*, *39*(4), 403–427. https://doi.org/10.1016/0022-3999(94)00157-Z

Bassett, M., Sperlinger, D., & Freeman, D. (2009). Fear of madness and persecutory delusions: Preliminary investigation of a new scale. *Psychosis*, *1*(1), 39–50. https://doi.org/10.1080/17522430802535031

Baumgartner, S. E., & Hartmann, T. (2011). The Role of Health Anxiety in Online Health Information Search. *Cyberpsychology, Behavior, and Social Networking*, *14*(10), 613–618. https://doi.org/10.1089/cyber.2010.0425

Beck, A. T. (1976). *Cognitive therapy and the emotional disorders* (p. 356). International Universities Press.

Beckett, J. J. (2009). *Health anxiety and hypochondriasis: The patient's perspective* [Masters]. Massey University.

Birnie, K. A., Sherry, S. B., Doucette, S., Sherry, D. L., Hadjistavropoulos, H. D., & Stewart, S. H. (2013). The Interpersonal Model of Health Anxiety: Testing predicted paths and model specificity. *Personality and Individual Differences*, *54*(7), 856–861. https://doi.org/10.1016/j.paid.2012.12.028

Bleichhardt, G., & Hiller, W. (2007). Hypochondriasis and health anxiety in the German population. *British Journal of Health Psychology*, *12*(4), 511–523. https://doi.org/10.1348/135910706X146034

Bouman, T. K. (2002). A community-based psychoeducational group approach to hypochondriasis. *Psychotherapy and Psychosomatics*, *71*(6), 326–332. https://doi.org/10.1159/000065995

Bound, F. (2006). Hypochondria. *The Lancet*, *367*(9505), 105.

Brennan, N., Barnes, R., Calnan, M., Corrigan, O., Dieppe, P., & Entwistle, V. (2013). Trust in the health-care provider–patient relationship: A systematic mapping review of the evidence base. *International Journal for Quality in Health Care*, *25*(6), 682–688. https://doi.org/10.1093/intqhc/mzt063

Broom, A. (2005). Virtually He@lthy: The Impact of Internet Use on Disease Experience and the Doctor-Patient Relationship. *Qualitative Health Research*, *15*(3), 325–345. https://doi.org/10.1177/1049732304272916

Brown, P. (1995). Naming and Framing: The Social Construction of Diagnosis and Illness. *Journal of Health and Social Behavior*, 34–52. JSTOR. https://doi.org/10.2307/2626956

Brown, W. (2006). American Nightmare: Neoliberalism, Neoconservatism, and De-Democratization. *Political Theory*, *34*(6), 690–714. JSTOR.

Burr, V. (2015). *Social Constructionism*. Taylor & Francis Group. http://ebookcentral.proquest.com/lib/massey/detail.action?docID=2011179

Burton, R. (1621). *The Anatomy of Melancholy*. https://search-proquest-com.ezproxy.massey.ac.nz/docview/2240863184?&imgSeq=1

Butler, T., & Gribben, J. G. (2010). Biologic and clinical significance of molecular profiling in Chronic Lymphocytic Leukemia. *Blood Reviews*, *24*(3), 135–141. https://doi.org/10.1016/j.blre.2010.03.004

Buwalda, F. M., Bouman, T. K., & van Duijn, M. A. J. (2007). Psychoeducation for hypochondriasis: A comparison of a cognitive-behavioural approach and a problem-solving approach. *Behaviour Research and Therapy*, *45*(5), 887–899. https://doi.org/10.1016/j.brat.2006.08.004

Bylund, C. L., Gueguen, J. A., D'Agostino, T. A., Li, Y., & Sonet, E. (2010). Doctor–Patient Communication About Cancer-Related Internet Information. *Journal of Psychosocial Oncology*, *28*(2), 127–142. https://doi.org/10.1080/07347330903570495

Cabrera-Perona, V., Buunk, A. p., Terol-Cantero, M. c., Quiles-Marcos, Y., & Martín-Aragón, M. (2017). Social comparison processes and catastrophising in fibromyalgia: A path analysis. *Psychology & Health*, *32*(6), 745–764.

Cahill, E., Lewis, L. M., Barg, F. K., & Bogner, H. R. (2009). You Don't Want to Burden Them. *Journal of Family Nursing*, *15*(3), 295–317. https://doi.org/10.1177/1074840709337247

Cheyne, G. (1733). *The English malady: Or, a treatise of nervous diseases of all kinds.*

Commons, D., Greenwood, K. M., & Anderson, R. A. (2016). A Preliminary Investigation into Worry about Mental Health: Development of the Mental Health Anxiety Inventory. *Behavioural and Cognitive Psychotherapy*, *44*(3), 347–360. https://doi.org/10.1017/S1352465815000454

Conrad, P., & Barker, K. K. (2010). The Social Construction of Illness: Key Insights and Policy Implications. *Journal of Health and Social Behavior*, *51*(1_suppl), S67–S79. https://doi.org/10.1177/0022146510383495

Conroy, R. M., Smyth, O., Siriwardena, R., & Fernandes, P. (1999). Health anxiety and characteristics of self-initiated general practitioner consultations. *Journal of Psychosomatic Research*, *46*(1), 45–50. https://doi.org/10.1016/S0022-3999(98)00066-X

Crawford, R. (2006). Health as a meaningful social practice. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, *10*(4), 401–420. https://doi.org/10.1177/1363459306067310

Creed, F., & Barsky, A. (2004). A systematic review of the epidemiology of somatisation disorder and hypochondriasis. *Journal of Psychosomatic Research*, *56*(4), 391–408. https://doi.org/10.1016/S0022-3999(03)00622-6

Cromby, J., & Willis, M. E. H. (2014). Nudging into subjectification: Governmentality and psychometrics. *Critical Social Policy*, *34*(2), 241–259. https://doi.org/10.1177/0261018313500868

Deacon, B., & Abramowitz, J. S. (2008). Is Hypochondriasis Related to Obsessive-Compulsive Disorder, Panic Disorder, or Both? An Empirical Evaluation. *Journal of Cognitive Psychotherapy*, *22*(2), 115.

Dillon, B. (2010). *Tormented Hope:Nine Hypochondriac Lives*. Penguin Books Ltd.

Dowbiggin, I. R. (2009). High Anxieties: The Social Construction of Anxiety Disorders. *The Canadian Journal of Psychiatry*, *54*(7), 429–436. https://doi.org/10.1177/070674370905400703

Eastin, M. S., & Guinsler, N. M. (2006). Worried and Wired: Effects of Health Anxiety on Information-Seeking and Health Care Utilization Behaviors. *CyberPsychology & Behavior*, *9*(4), 494–498. https://doi.org/10.1089/cpb.2006.9.494

Eilenberg, T., Kronstrand, L., Fink, P., & Frostholm, L. (2013). Acceptance and commitment group therapy for health anxiety – Results from a pilot study. *Journal of Anxiety Disorders*, *27*(5), 461–468. https://doi.org/10.1016/j.janxdis.2013.06.001

Evans, J., Ziebland, S., & Pettitt, A. R. (2012). Incurable, invisible and inconclusive: Watchful waiting for chronic lymphocytic leukaemia and implications for doctor-patient communication. *European Journal of Cancer Care*, *21*(1), 67–77. https://doi.org/10.1111/j.1365-2354.2011.01278.x

Eysenbach, G., & Köhler, C. (2002). How do consumers search for and appraise health information on the world wide web? Qualitative study using focus groups, usability tests, and in-depth interviews. *BMJ*, *324*(7337), 573–577. https://doi.org/10.1136/bmj.324.7337.573

Fallon, B. A., Ahern, D. K., Pavlicova, M., Slavov, I., Skritskya, N., & Barsky, A. J. (2017). A Randomized Controlled Trial of Medication and Cognitive-Behavioral Therapy for Hypochondriasis. *American Journal of Psychiatry*, *174*(8), 756–764. https://doi.org/10.1176/appi.ajp.2017.16020189

Fallon, B. A., Petkova, E., Skritskaya, N., Sanchez-Lacay, A., Schneier, F., Vermes, D., Cheng, J., & Liebowitz, M. R. (2008). A double-masked, placebo-controlled study of fluoxetine for hypochondriasis. *Journal of Clinical Psychopharmacology*, *28*(6), 638–645. https://doi.org/10.1097/JCP.0b013e31818d21cf

Fergus, T. A., & Bardeen, J. R. (2013). Anxiety sensitivity and intolerance of uncertainty: Evidence of incremental specificity in relation to health anxiety. *Personality and Individual Differences*, *55*(6), 640–644. https://doi.org/10.1016/j.paid.2013.05.016

Ferguson, E. (2009). A taxometric analysis of health anxiety. *Psychological Medicine*, *39*(2), 277–285. https://doi.org/10.1017/S0033291708003322

Fink, P., Ørnbøl, E., Toft, T., Sparle, K. C., Frostholm, L., & Olesen, F. (2004). A New, Empirically Established Hypochondriasis Diagnosis. *American Journal of Psychiatry*, *161*(9), 1680–1691. https://doi.org/10.1176/appi.ajp.161.9.1680

Fox, S., & Duggan, M. (2013). *Health Online 2013*. Pew Internet and American Life Project. https://www.pewinternet.org/wp-content/uploads/sites/9/media/Files/Reports/PIP_HealthOnline.pdf

Freud, S. (1956). *Collected Papers*. Hogarth.

García-Campayo, J., Lobo, A., Pérez-Escheverría, M. J., & Campos, R. (1998). Three forms of somatization presenting in primary care settings in Spain. *Journal of Nervous and Mental Disease*, *186*(9), 554–560. https://doi.org/10.1097/00005053-199809000-00006

Gergen, K. (2001). Psychological Science in a Postmodern Context. *American Psychologist*, *56*(10), 803–813.

Ginsberg, D. L. (2004). Women and Anxiety Disorders: Implications for Diagnosis and Treatment. *CNS Spectrums*, *9*(9), 1–3. https://doi.org/10.1017/S1092852900001978

Gorvin, L., & Brown, D. (2012). The psychology of feeling like a burden: A review of the literature. *Social Psychology Review*, *14*(1), 28–41.

Greeven, A., van Balkom, A. J. L. M., van der Leeden, R., Merkelbach, J. W., van den Heuvel, O. A., & Spinhoven, P. (2009). Cognitive behavioral therapy versus paroxetine in the treatment of hypochondriasis: An 18-month naturalistic follow-up. *Journal of Behavior Therapy and Experimental Psychiatry*, *40*(3), 487–496. https://doi.org/10.1016/j.jbtep.2009.06.005

Hadjistavropoulos, H. D., Alberts, N. M., & Asmundson, G. J. G. (2014). Health anxiety. In E. A. Storch & D. McKay (Eds.), *Obsessive-compulsive disorder and its spectrum: A life-span approach.* (pp. 205–222). American Psychological Association. https://doi.org/10.1037/14323-011

Hart, J., & Björgvinsson, T. (2010). Health anxiety and hypochondriasis: Description and treatment issues highlighted through a case illustration. *Bulletin of the Menninger Clinic*, *74*(2), 122–140. https://doi.org/10.1521/bumc.2010.74.2.122

Hartmann, A. S., Cordes, M., Hirschfeld, G., & Vocks, S. (2019). Affect and worry during a checking episode: A comparison of individuals with symptoms of obsessive-compulsive disorder, anorexia nervosa, bulimia nervosa, body dysmorphic disorder, illness anxiety disorder, and panic disorder. *Psychiatry Research*, *272*, 349–358. https://doi.org/10.1016/j.psychres.2018.12.132

Heath, S. (2011). Hypochondria: Medical condition, creative malady. *Brain*, *134*(4), 1244–1249. https://doi.org/10.1093/brain/awr006

Hedman, E. (1), Ljótsson, B. (1), Andersson, E. (1), Rück, C. (1), Andersson, G. (1, 2), & Lindefors, N. (1). (2010). Effectiveness and cost offset analysis of group CBT for hypochondriasis delivered in a psychiatric setting: An open trial. *Cognitive Behaviour Therapy*, *39*(4), 239–250. https://doi.org/10.1080/16506073.2010.496460

Hedman, Erik, Andersson, G., Andersson, E., Ljótsson, B., Rück, C., Asmundson, G. J. G., & Lindefors, N. (2011). Internet-based cognitive–behavioural therapy for severe health anxiety: Randomised controlled trial. *British Journal of Psychiatry*, *198*(3), 230–236. https://doi.org/10.1192/bjp.bp.110.086843

Hedman, Erik, Axelsson, E., Andersson, E., Lekander, M., & Ljótsson, B. (2016). Exposure-based cognitive–behavioural therapy via the internet and as bibliotherapy for somatic symptom disorder and illness anxiety disorder: Randomised controlled trial. *British Journal of Psychiatry*, *209*(5), 407–413. https://doi.org/10.1192/bjp.bp.116.181396

Helbig-Lang, S., & Petermann, F. (2010). Tolerate or Eliminate? A Systematic Review on the Effects of Safety Behavior Across Anxiety Disorders. *Clinical Psychology: Science and Practice*, *17*(3), 218–233. https://doi.org/10.1111/j.1468-2850.2010.01213.x

Henwood, F., Wyatt, S., Hart, A., & Smith, J. (2003). 'Ignorance is bliss sometimes': Constraints on the emergence of the 'informed patient' in the changing landscapes of health information. *Sociology of Health & Illness*, *25*(6), 589–607. https://doi.org/10.1111/1467-9566.00360

Hirsch, C. R., & Holmes, E. A. (2007). Mental imagery in anxiety disorders. *Psychiatry*, *6*(4), 161–165. https://doi.org/10.1016/j.mppsy.2007.01.005

Holder-Perkins, V., Wise, T. N., & Williams, D. E. (2000). Hypochondriacal Concerns: Management Through Understanding. *Primary Care Companion to The Journal of Clinical Psychiatry*, *2*(4), 117–121.

Holstein, J. A., & Gubrium, J. F. (2008). *Handbook of Constructionist Research*. Guilford Press.

Horenstein, A. (1), Heimberg, R. g. (1), Rogers, A. h. (2), Bakhshaie, J. (2), & Zvolensky, M. j. (2, 3,4). (2019). Examining the Role of Anxiety Sensitivity and Intolerance of Uncertainty in the Relationship Between Health Anxiety and Likelihood of Medical Care Utilization. *Cognitive Therapy and Research*, *43*(1), 55–65. https://doi.org/10.1007/s10608-018-9980-z

Kim, K. (2006). *The Social Construction of Disease: From Scrapie to Prion*. Routledge. https://doi.org/10.4324/9780203008256

Kirmayer, L. J., & Robbins, J. M. (1991). Three forms of somatization in primary care: Prevalence, co-occurrence, and sociodemographic characteristics. *The Journal of Nervous and Mental Disease*, *179*(11), 647–655.

Koeck, C. (2014). Imbalance of power between patients and doctors. *BMJ*, *342*, 7485.

Koerner, N., & Dugas, M. J. (2008). A Cognitive Model of Generalized Anxiety Disorder: The Role of Intolerance of Uncertainty. In *Worry and its Psychological Disorders* (pp. 201–216). John Wiley & Sons, Ltd. https://doi.org/10.1002/9780470713143.ch12

Köteles, F., Freyler, A., Kökönyei, G., & Bárdos, G. (2015a). Family background of modern health worries, somatosensory amplification, and health anxiety: A questionnaire study. *Journal of Health Psychology*, *20*(12), 1549–1557. https://doi.org/10.1177/1359105313516661

Köteles, F., Freyler, A., Kökönyei, G., & Bárdos, G. (2015b). Family background of modern health worries, somatosensory amplification, and health anxiety: A questionnaire study. *Journal of Health Psychology*, *20*(12), 1549–1557. https://doi.org/10.1177/1359105313516661

Lecci, L., & Cohen, D. J. (2002). Perceptual consequences of an illness-concern induction and its relation to hypochondriacal tendencies. *Health Psychology*, *21*(2), 147–156. https://doi.org/10.1037//0278-6133.21.2.147

Lejoyeux, M., Avril, M., Richoux, C., Embouazza, H., & Nivoli, F. (2008). Prevalence of exercise dependence and other behavioral addictions among clients of a Parisian fitness room. *Comprehensive Psychiatry*, *49*(4), 353–358. https://doi.org/10.1016/j.comppsych.2007.12.005

Lincoln, Y. S., Guba, E. G., & Guba, E. G. (2016). *The Constructivist Credo*. Routledge. https://doi.org/10.4324/9781315418810

Lipsitt, Don. R. (2001). The Patient-Physician Relationship in the Treatment of Hypochondriasis. In Don. R. Lipsitt & V. Starcevic, *Modern Perspectives on an Ancient Malady* (pp. 265–290). Oxford University Press.

Lockhart, E. (2016). Health anxiety in children and parents. *BMJ*, i2891. https://doi.org/10.1136/bmj.i2891

Looper, K. J., & Kirmayer, L. J. (2002). Behavioral medicine approaches to somatoform disorders. *Journal of Consulting and Clinical Psychology*, *70*(3), 810–827. https://doi.org/10.1037/0022-006X.70.3.810

Luberto, C. M., Magidson, J. F., & Blashill, A. J. (2017). A Case Study of Individually Delivered Mindfulness-Based Cognitive Behavioral Therapy for Severe Health Anxiety. *Cognitive and Behavioral Practice*, *24*(4), 484–495. https://doi.org/10.1016/j.cbpra.2016.10.001

MacSwain, K. L. H., Sherry, S. B., Stewart, S. H., Watt, M. C., Hadjistavropoulos, H. D., & Graham, A. R. (2009). Gender differences in health anxiety: An investigation of the interpersonal model of health anxiety. *Personality and Individual Differences*, *47*(8), 938–943. https://doi.org/10.1016/j.paid.2009.07.020

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample Size in Qualitative Interview Studies: Guided by Information Power. *Qualitative Health Research*, *26*(13), 1753–1760.

Marcus, D. K. (1999). The cognitive-behavioral model of hypochondriasis: Misinformation and triggers. *Journal of Psychosomatic Research*, *47*(1), 79–91. https://doi.org/10.1016/S0022-3999(99)00008-2

Marcus, D. K., Hughes, K. T., & Arnau, R. C. (2008). Health anxiety, rumination, and negative affect: A mediational analysis. *Journal of Psychosomatic Research*, 7.

Marshall, T., Jones, D. P. H., Ramchandani, P. G., Stein, A., & Bass, C. (2007). Intergenerational transmission of health beliefs in somatoform disorders: Exploratory study. *British Journal of Psychiatry*, *191*(5), 449–450. https://doi.org/10.1192/bjp.bp.107.035261

Martin, A., & Jacobi, F. (2006). Features of Hypochondriasis and Illness Worry in the General Population in Germany:*PsychosomaticMedicine*,*68*(5),770–777. https://doi.org/10.1097/01.psy.0000238213.04984.b0

McCann, J. J. (2016). Is mental illness socially constructed? *Journal of Applied Psychology and Social Science*, *2*(1), 1–11.

Mental Health Inquiry. (2018). *He Ara Oranga*. Government Inquiry into Mental Health and Addiciton. https://mentalhealth.inquiry.govt.nz/assets/Summary-reports/He-Ara-Oranga.pdf

Micale, M. S. (2008). *Hysterical Men*. Harvard University Press.

Muse, K., McManus, F., Hackmann, A., Williams, M., & Williams, M. (2010). Intrusive imagery in severe health anxiety: Prevalence, nature and links with memories and maintenance cycles. *Behaviour Research and Therapy*, *48*(8), 792–798. https://doi.org/10.1016/j.brat.2010.05.008

Muse, K., McManus, F., Leung, C., Meghreblian, B., & Williams, J. M. G. (2012). Cyberchondriasis: Fact or fiction? A preliminary examination of the relationship between health anxiety and searching for health information on the Internet. *Journal of Anxiety Disorders*, *26*(1), 189–196. https://doi.org/10.1016/j.janxdis.2011.11.005

Newby, J. M., Haskelberg, H., Hobbs, M. J., Mahoney, A. E. J., Mason, E., & Andrews, G. (2020). The effectiveness of internet-delivered cognitive behavioural therapy for health anxiety in routine care. *Journal of Affective Disorders*, *264*, 535–542. https://doi.org/10.1016/j.jad.2019.11.087

Newby, J. M., Hobbs, M. J., Mahoney, A. E. J., Wong, S. (Kelvin), & Andrews, G. (2017). DSM-5 illness anxiety disorder and somatic symptom disorder: Comorbidity, correlates, and overlap with DSM-IV hypochondriasis. *Journal of Psychosomatic Research*, *101*, 31–37. https://doi.org/10.1016/j.jpsychores.2017.07.010

Norr, A. M., Capron, D. W., & Schmidt, N. B. (2014). Medical information seeking: Impact on risk for anxiety psychopathology. *Journal of Behavior Therapy and Experimental Psychiatry*, *45*(3), 402–407. https://doi.org/10.1016/j.jbtep.2014.04.003

Noyes Jr, R. (2005). Hypochondrais: A review. In M. Maj, H. S. Akiskal, J. Mezzich, & A. Okasha (Eds.), *Somatoform Disorders* (pp. 129–159). John Wiley & Sons.

Noyes, R. (2011). The Transformation of Hypochondriasis in British Medicine, 1680-1830. *Social History of Medicine*, *24*(2), 281–298. https://doi.org/10.1093/shm/hkq052

Noyes, Russell, Carney, C. P., Hillis, S. L., Jones, L. E., & Langbehn, D. R. (2005). Prevalence and Correlates of Illness Worry in the General Population. *Psychosomatics*, *46*(6), 529–539. https://doi.org/10.1176/appi.psy.46.6.529

Noyes, Russell, Stuart, S., Langbehn, D. R., Happel, R. L., Longley, S. L., & Yagla, S. J. (2002). Childhood Antecedents Of Hypochondriasis. *Psychosomatics*, *43*(4), 282–289. https://doi.org/10.1176/appi.psy.43.4.282

Noyes, Russell, Stuart, S. P., Langbehn, D. R., Happel, R. L., Longley, S. L., Muller, B. A., & Yagla, S. J. (2003). Test of an Interpersonal Model of Hypochondriasis: *Psychosomatic Medicine*, *65*(2), 292–300. https://doi.org/10.1097/01.PSY.0000058377.50240.64

O'Bryan, E. M., Luberto, C. M., Kraemer, K. M., & McLeish, A. C. (2018). An examination of mindfulness skills in terms of affect tolerance among individuals with elevated levels of health anxiety. *Anxiety, Stress, & Coping*, *31*(6), 702–713. https://doi.org/10.1080/10615806.2018.1521515

O'Bryan, E. M., & McLeish, A. C. (2017). An Examination of the Indirect Effect of Intolerance of Uncertainty on Health Anxiety Through Anxiety Sensitivity Physical Concerns. *Journal of Psychopathology and Behavioral Assessment*, *39*(4), 715–722. https://doi.org/10.1007/s10862-017-9613-y

Olatunji, B. O., Etzel, E. N., Tomarken, A. J., Ciesielski, B. G., & Deacon, B. (2011). The effects of safety behaviors on health anxiety: An experimental investigation. *Behaviour Research and Therapy*, *49*(11), 719–728. https://doi.org/10.1016/j.brat.2011.07.008

Olatunji, B. O., Kauffman, B. Y., Meltzer, S., Davis, M. L., Smits, J. A. J., & Powers, M. B. (2014). Cognitive-behavioral therapy for hypochondriasis/health anxiety: A meta-analysis of treatment outcome and moderators. *Behaviour Research and Therapy*, *58*, 65–74. https://doi.org/10.1016/j.brat.2014.05.002

Ottosen, M. J., Sedlock, E. W., Aigbe, A. O., Bell, S. K., Gallagher, T. H., & Thomas, E. J. (2018). Long-term Impacts Faced by Patients and Families after Harmful Healthcare Events. *Journal of Patient Safety*. https://doi.org/10.1097/PTS.0000000000000451

Persing, J. S., Stuart, S. P., Noyes, R., & Happel, R. L. (2000). Hypochondriasis: The Patient's Perspective. *The International Journal of Psychiatry in Medicine*, *30*(4), 329–342. https://doi.org/10.2190/KMXW-T53N-BTDW-GTGH

Pharr, J. R., Dodge Francis, C., Terry, C., & Clark, M. C. (2014). *Culture, Caregiving, and Health: Exploring the Influence of Culture on Family Caregiver Experiences* [Research article]. International Scholarly Research Notices. https://doi.org/10.1155/2014/689826

Phillips, K. A. (2002). The obsessive-compulsive spectrums. *The Psychiatric Clinics of North America*, *25*(4), 791–809.

Pilowsky, I. (1967). Dimensions of Hypochondriasis. *British Journal of Psychiatry*, *113*(494), 89–93. https://doi.org/10.1192/bjp.113.494.89

Powers, M. B., Smits, J. A. J., & Telch, M. J. (2004). Disentangling the Effects of Safety-Behavior Utilization and Safety-Behavior Availability During Exposure-Based Treatment: A Placebo-Controlled Trial. *Journal of Consulting & Clinical Psychology*, *72*(3), 448.

Pugh, N. E., & Hadjistavropoulos, H. D. (2011). Is anxiety about health associated with desire to exercise, physical activity, and exercise dependence? *Personality and Individual Differences*, *51*(8), 1059–1062. https://doi.org/10.1016/j.paid.2011.08.025

Rachman, S. (2002). A cognitive theory of compulsive checking. *Behaviour Research and Therapy*, *40*(6), 625–639. https://doi.org/10.1016/S0005-7967(01)00028-6

Rachman, S. (2012). Health anxiety disorders: A cognitive construal. *Behaviour Research and Therapy*, *50*(7), 502–512. https://doi.org/10.1016/j.brat.2012.05.001

Rachman, S., Radomsky, A. S., & Shafran, R. (2008). Safety behaviour: A reconsideration. *Behaviour Research and Therapy*, *46*(2), 163–173. https://doi.org/10.1016/j.brat.2007.11.008

Rapmund, V., & Moore, C. (2000). Women's stories of depression: A constructivist approach. *South African Journal of Psychology*, *30*(2), 20. https://doi.org/10.1177/008124630003000203

Rapport, F., Wainwright, P., & Wainwright, P. (2018). *The Self in Health and Illness: Patients, Professionals and Narrative Identity*. CRC Press. https://doi.org/10.1201/9781315378831

Reiser, S. J., McMillan, K. A., Wright, K. D., & Asmundson, G. J. G. (2014). Adverse childhood experiences and health anxiety in adulthood. *Child Abuse & Neglect*, *38*(3), 407–413. https://doi.org/10.1016/j.chiabu.2013.08.007

Rose, N. S. (2007). *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century*. Princeton University Press.

Sadock, B. L., Sadock, V. A., & Ruiz, P. (2014). *Kaplan and Sadock's Synopsis of Psychiatry: Behavioral Sciences/Clinical Psychiatry* (11th ed.). Wolters Kluwer Health.

Salkovskis, P. M., Rimes, K. A., Warwick, H. M. C., & Clark, D. M. (2002). The Health Anxiety Inventory: Development and validation of scales for the measurement of health anxiety and hypochondriasis. *Psychological Medicine*, *32*(5), 843–853. https://doi.org/10.1017/S0033291702005822

Salkovskis, Paul M. (1996). The cognitive approach to anxiety: Threat beliefs, safety-seeking behavior, and the special case of health anxiety and obsessions. In *Frontiers of cognitive therapy* (pp. 48–74). Guilford Press.

Salkovskis, Paul M., & Warwick, H. (2001). Making sense of hypochondriasis: A cognitive theory of health anxiety. *Health Anxiety: Clinical and Research Perspectives on Hypochondriasis and Related Conditions*, 46–64.

Scarella, T. M., Laferton, J. A. C., Ahern, D. K., Fallon, B. A., & Barsky, A. (2016). The Relationship of Hypochondriasis to Anxiety, Depressive, and Somatoform Disorders. *Psychosomatics*, *57*(2), 200–207. https://doi.org/10.1016/j.psym.2015.10.006

Shalev, A. Y., Schreiber, S., Galai, T., & Melmed, R. N. (1993). Post-traumatic stress disorder following medical events. *British Journal of Clinical Psychology*, *32*(2), 247–253. https://doi.org/10.1111/j.2044-8260.1993.tb01052.x

Sherry, D. L., Sherry, S. B., Vincent, N. A., Stewart, S. H., Hadjistavropoulos, H. D., Doucette, S., & Hartling, N. (2014). Anxious attachment and emotional instability interact to predict health anxiety: An extension

of the interpersonal model of health anxiety. *Personality and Individual Differences*, *56*, 89–94. https://doi.org/10.1016/j.paid.2013.08.025

Singh, K. (2020). The Internet doctor is always in. A commentary on: "Online health research and health anxiety: A systematic review and conceptual integration." *Clinical Psychology: Science and Practice*, 1–3. https://doi.org/10.1111/cpsp.12323

Singh, K., & Brown, R. J. (2016a). From headache to tumour: An examination of health anxiety, health-related Internet use and 'query escalation.' *Journal of Health Psychology*, *21*(9), 2008–2020. https://doi.org/10.1177/1359105315569620

Singh, K., Fox, J. R. E., & Brown, R. J. (2016b). Health anxiety and Internet use: A thematic analysis. *Cyberpsychology: Journal of Psychosocial Research on Cyberspace*, *10*(2). https://doi.org/10.5817/CP2016-2-4

Skrabanek, P. (1994). *The death of humane medicine and the rise of coercive healthism*. Social Affairs Unit.

Sobal, J. (2017). *Weighty Issues: Fatness and Thinness as Social Problems*. Routledge. https://doi.org/10.4324/9781351328289

Sofaer, S. (1999). Qualitative methods: What are they and why use them? *Health Services Research*, *34*(5 Pt 2), 1101–1118.

Starcevic, V., & Berle, D. (2013). Cyberchondria: Towards a better understanding of excessive health-related Internet use. *Expert Review of Neurotherapeutics*, *13*(2), 205–213. https://doi.org/10.1586/ern.12.162

Starcevic, V., & Lipsitt, D. R. (2001). *Hypochondriasis: Modern Perspectives on an Ancient Malady*. Oxford University Press. http://eds.b.ebscohost.com.ezproxy.massey.ac.nz/eds/ebookviewer/ebook/bmxlYmtfXzI3MzgyM19fQU41?sid=51f10b7d-585f-4ab1-80de-b209aaadc216@sessionmgr103&vid=0&format=EB&rid=1

Starcevic, V., & Noyes Jr., R. (Eds.). (2014). *Hypochondriasis and Health Anxiety: A Guide for Clinicians*. Oxford University Press. http://eds.b.ebscohost.com.ezproxy.massey.ac.nz/eds/ebookviewer/ebook/bmxlYmtfXzc3OTUyMV9fQU41?sid=0b8d6bf7-e883-4676-b8d5-c9d5dd122952@pdc-v-sessmgr01&vid=0&format=EB

Stern, R., & Fernandez, M. (1991). Group cognitive and behavioural treatment for hypochondriasis. *BMJ*, *303*(6812), 1229–1231. https://doi.org/10.1136/bmj.303.6812.1229

Stol, Y. H., Schermer, M. H. N., & Asscher, E. C. A. (2016). Omnipresent Health Checks May Result in Over-responsibilization. *Public Health Ethics*, phw034. https://doi.org/10.1093/phe/phw034

Stuart, S., & Noyes, R. (1999). Attachment and Interpersonal Communication in Somatization. *Psychosomatics*, *40*(1), 34–43. https://doi.org/10.1016/S0033-3182(99)71269-7

Stuart, S., & Noyes, R. (2005). Treating Hypochondriasis with Interpersonal Psychotherapy. *Journal of Contemporary Psychotherapy*, *35*(3), 269–283. https://doi.org/10.1007/s10879-005-4320-5

Stuart, S., Noyes, R., Starcevic, V., & Barsky, A. (2008). An Integrative Approach to Somatoform Disorders Combining Interpersonal and Cognitive-behavioral Theory and Techniques. *Journal of Contemporary Psychotherapy*, *38*(1), 45–53. https://doi.org/10.1007/s10879-007-9067-8

Stumpers, S. (2012). An exploration of the experience and social construction of ageing: Perspectives from older adults in a healthy ageing program and those from Western Australian and Welsh communities. *Theses: Doctorates and Masters*. https://ro.ecu.edu.au/theses/2014

Tamres, L. K., Janicki, D., & Helgeson, V. S. (2002). Sex Differences in Coping Behavior: A Meta-Analytic Review and an Examination of Relative Coping. *Personality & Social Psychology Review (Lawrence Erlbaum Associates)*, *6*(1), 2–30. https://doi.org/10.1207/S15327957PSPR0601_1

Tan, S. S.-L., & Goonawardene, N. (2017). Internet Health Information Seeking and the Patient-Physician Relationship: A Systematic Review. *Journal of Medical Internet Research*, *19*(1). https://doi.org/10.2196/jmir.5729

Tanis, M., Hartmann, T., & te Poel, F. (2016). Online health anxiety and consultation satisfaction: A quantitative exploratory study on their relations. *Patient Education and Counseling*, *99*(7), 1227–1232. https://doi.org/10.1016/j.pec.2016.01.021

Teater, B. (2015). Social Work Theory. In J. D. Wright (Ed.), *International Encyclopedia of the Social & Behavioral Sciences (Second Edition)* (pp. 813–820). Elsevier. https://doi.org/10.1016/B978-0-08-097086-8.28092-6

Tennen, H., Mckee, T., & Affleck, G. (2000). *Social Comparison Processes in Health and Illness* (pp. 443–483). https://doi.org/10.1007/978-1-4615-4237-7_21

Thorgaard, M., Frostholm, L., Walker, L., Stengaard-Pedersen, K., Karlsson, M., Jensen, J., Fink, P., & Rask, C. (2017a). Effects of maternal health anxiety on children's health complaints, emotional symptoms, and

quality of life. *European Child & Adolescent Psychiatry*, *26*(5), 591–601. https://doi.org/10.1007/s00787-016-0927-1

Thorgaard, M. V., Frostholm, L., Walker, L., Jensen, J. S., Morina, B., Lindegaard, H., Salomonsen, L., & Rask, C. U. (2017b). Health anxiety by proxy in women with severe health anxiety: A case control study. *Journal of Anxiety Disorders*, *52*, 8–14. https://doi.org/10.1016/j.janxdis.2017.09.001

Thwaites, R., & Freeston, M. H. (2005). Safety-Seeking Behaviours: Fact or Function? How Can We Clinically Differentiate Between Safety Behaviours and Adaptive Coping Strategies Across Anxiety Disorders? *Behavioural and Cognitive Psychotherapy*, *33*(2), 177–188. https://doi.org/10.1017/S1352465804001985

Todres, L. (2007). *Embodied enquiry: Phenomenological touchstones for research, psychotherapy and spirituality*. Palgrave Macmillan.

Turner, B. (2007). *Medical Power and Social Knowledge* (2nd ed.). https://doi.org/10.4135/9781446250426

Tyrer, H., Tyrer, P., & Barrett, B. (2013). Influence of dependent personality status on the outcome and health service costs of health anxiety. *International Journal of Social Psychiatry*, *59*(3), 274–280. https://doi.org/10.1177/0020764012438483

Wagner, E. H., & Von Korff, M. (1996). Improving outcomes in chronic illness. *Managed Care Quarterly*, *4*(2), 12–25.

Waldinger, R. J., Schulz, M. S., Barsky, A. J., & Ahern, D. K. (2006). Mapping the Road From Childhood Trauma to Adult Somatization: The Role of Attachment: *Psychosomatic Medicine*, *68*(1), 129–135. https://doi.org/10.1097/01.psy.0000195834.37094.a4

Walker, J., Vincent, N., Furer, P., Cox, B., & Kevin Kjernisted. (1999). Treatment preference in hypochondriasis. *Journal of Behavior Therapy and Experimental Psychiatry*, *30*(4), 251–258. https://doi.org/10.1016/S0005-7916(99)00027-0

Walker, L. S. (2019). Commentary: Understanding Somatic Symptoms: From Dualism to Systems, Diagnosis to Dimensions, Clinical Judgement to Clinical Science. *Journal of Pediatric Psychology*, *44*(7), 862–867. https://doi.org/10.1093/jpepsy/jsz050

Wallis, K., Sutton, D., & Bassett, S. (2018). Sensory Modulation for People with Anxiety in a Community Mental Health Setting. *Occupational Therapy in Mental Health*, *34*(2), 122–137. https://doi.org/10.1080/0164212X.2017.1363681

Weck, F., Gropalis, M., Hiller, W., & Bleichhardt, G. (2015). Effectiveness of cognitive-behavioral group therapy for patients with hypochondriasis (health anxiety). *Journal of Anxiety Disorders*, *30*, 1–7. https://doi.org/10.1016/j.janxdis.2014.12.012

White, R. W., & Horvitz, E. (2009). Cyberchondria: Studies of the escalation of medical concerns in Web search. *ACM Transactions on Information Systems*, *27*(4), 23:1–23:37. https://doi.org/10.1145/1629096.1629101

Williams, P. G., Smith, T. W., & Jordan, K. D. (2010). Health anxiety and hypochondriasis: Interpersonal extensions of the cognitive–behavioral perspective. In *Interpersonal processes in the anxiety disorders: Implications for understanding psychopathology and treatment.* (2009-19610-010; pp. 261–284). American Psychological Association. https://doi.org/10.1037/12084-010

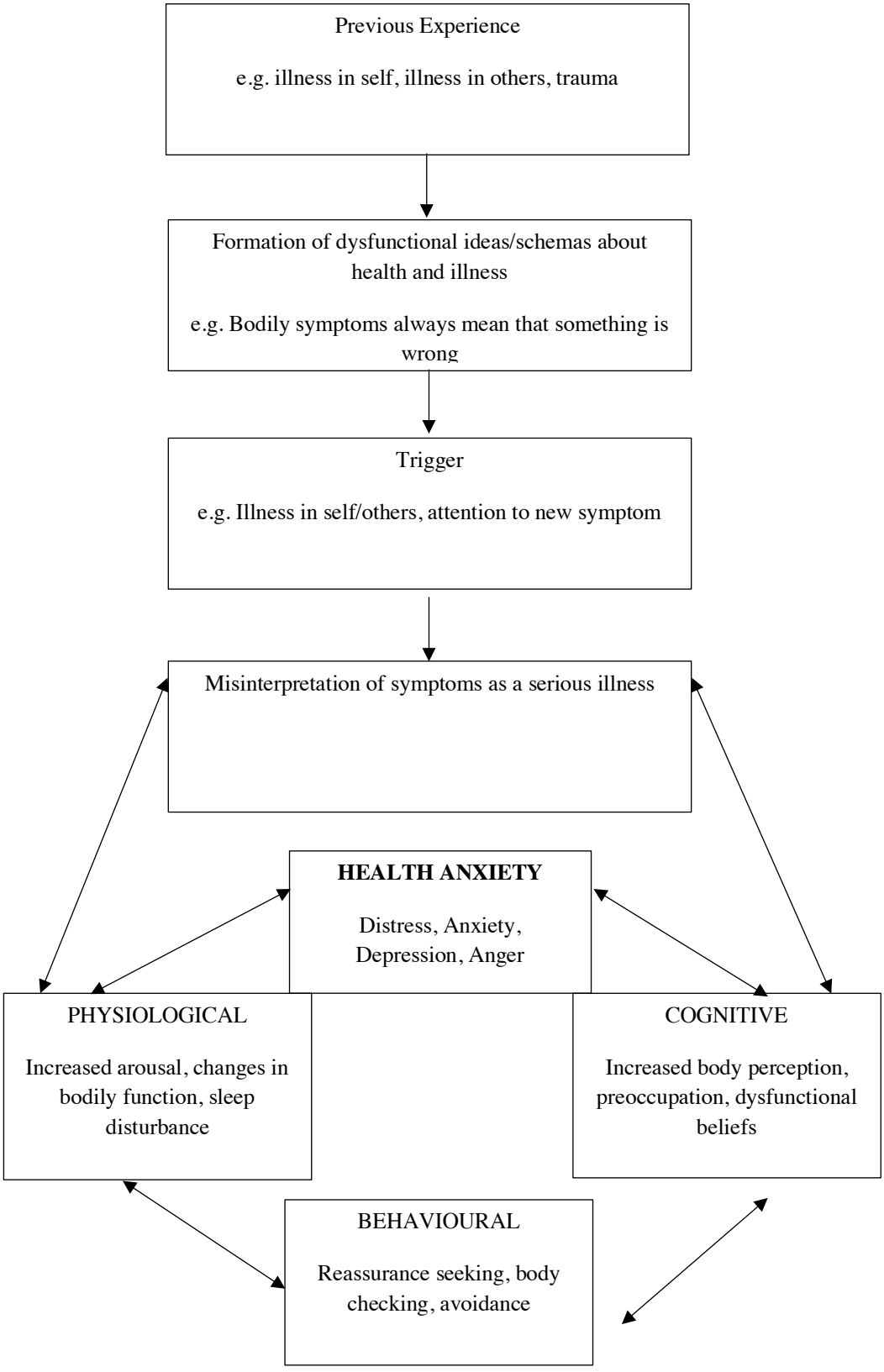
Wilson, M. (1993). DSM-III and the Transformation of American Psychiatry: A History. *American Journal of Psychiatry*, *150*(3), 339–410.

Wright, K. D., Reiser, S. J., & Delparte, C. A. (2017). The relationship between childhood health anxiety, parent health anxiety, and associated constructs. *Journal of Health Psychology*, *22*(5), 617–626. https://doi.org/10.1177/1359105315610669

Yan, Y. (2018). The ethics and politics of patient-physician mistrust in contemporary China. *Developing World Bioethics*, *18*(1), 7–15. https://doi.org/10.1111/dewb.12155

Appendix A

Diagram of the Cognitive Model Adapted from Salkovskis & Warwick (2008)



Appendix B

Diagnostic and Statistical Manual of Mental Disorders (DSM) Criteria for Hypochondriasis

DSM-III	*DSM-III-R*	*DSM-IV-TR*
A. The predominant disturbance is an unrealistic interpretation of physical signs or sensations as abnormal, leading to preoccupation with the fear or belief of having a serious disease.	A. Preoccupation with the fear of having, or the belief that one has, a serious disease, based on the person's interpretation of physical signs or sensations as evidence of physical illness.	A. A preoccupation with fears of having, or the idea that one has, a serious disease based on the person's misinterpretation of bodily symptoms.
B. Thorough physical evaluation does not support the diagnosis of any physical disorder that can account for the physical signs or sensations or for the individual's unrealistic interpretation of them	B. Appropriate physical evaluation does not support the diagnosis of any physical disorder that can account for the physical signs or sensations or the person's unwarranted interpretation of them, and the symptoms in (A) are not just symptoms of panic attacks	B. The preoccupation persists despite appropriate medical evaluation and reassurance.
C. The unrealistic fear or belief of having a disease persists despite medical reassurance and causes impairment in social or occupational functioning.	C. The fear of having, or belief that one has, a disease persists despite medical reassurance.	C. The belief in Criterion (A) is not of delusional intensity (as in Delusional Disorder, Somatic Type) and is not restricted to a circumscribed concern about appearance (as in Body Dysmorphic disorder).
D. Not due to any other mental disorder such as Schizophrenia, Affective Disorder, or Somatization Disorder	D. Duration of the disturbance is at least 6 months	D. The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Appendix B (continued)

DSM-III	*DSM-III-R*	*DSM-IV-TR*
	E. The belief in A is not of delusional intensity, as in Delusional Disorder, Somatic Type (i.e. the person can acknowledge the possibility that his or her fear of having, or belief that he or she has, a serious disease is unfounded).	E. The duration of the disturbance is at least 6 months.
		F. The preoccupation is not better accounted for by Generalized Anxiety Disorder, Obsessive Compulsive Disorder, Panic Disorder, a Major Depressive episode, Separation Anxiety, or another Somatoform Disorder.

Appendix C

Study Information Sheet

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

Exploring the experiences of people who self-identify as being excessively worried about their health

INFORMATION SHEET

My name is Victoria Thompson and I'm a Doctor of Clinical Psychology student at Massey University. I am inviting you to participate in a project called 'Exploring the experiences of people who self-identify as being excessively worried about their health.'

Participant Identification and Recruitment

Participants have been recruited through advertisements in various public places. Participants are 18 years or over, and consist of those who self-identify as continually worrying about their health. Participants will be excluded if they are currently suffering with an unstable or life threatening medical or neurological disorder, have a current diagnosis of psychotic symptoms or a high risk of suicide. Participants will also be excluded if they are too medically unwell or distressed to attend the interview. The study will seek to include 12 participants, as data saturation for qualitative research occurs at around 12 participants. Following completion of the interview, participants will be given a $20 petrol voucher as a token of our appreciation.

If you participate, what will you need to do?

Participants will be asked to engage in a 60-90minute interview with the researcher. This will be arranged at a convenient time and location for the participant and the researcher. The researcher will be exploring how you experience and manage your health worries. Participant interviews will be transcribed following interview.

If you participate, what are the risks of being involved?

You may have some concerns about being identified in this study. Participants are reassured that their personal information will remain confidential, and the recordings and transcripts of the interviews will only be viewed by the research team. Participants may access these transcripts at any time. Participants will be given alias names, and data will be stored in password protected files.

Participant's Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- ask for the recorder to be turned off at any time during the interview.
- withdraw from the study at any time
- access your transcript at any time
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- be given access to a summary of the project findings when it is concluded.

Project Contacts

- This projected is supervised by Dr Bev Haarhoff (B.A.Haarhoff@massey.ac.nz) and Dr Clifford van Ommen (C.VanOmmen@massey.ac.nz)
- Researcher: Victoria Thompson
- If you have any questions about the project please contact the researcher and/or the supervisors named above.

"This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named above are responsible for the ethical conduct of this research.

If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher(s), please contact Dr Brian Finch, Director, Research Ethics, telephone 06 356 9099 x 86015, email humanethics@massey.ac.nz".

Appendix D.

Study Demographic Questionnaire

Demographic Questionnaire

How old are you?

What is your gender:

What is your marital status?

Single (never married) ☐

In a relationship ☐

Living with partner ☐

Married ☐

Separated ☐

Widowed ☐

Divorced

What is your ethnicity?

☐

NZ Maori ☐

NZ European ☐

Pacific Islander ☐

Asian ☐

Other (Please Describe)

What is your highest level of education?

☐

High school attendance ☐

School certificate or NCEA Level 1 ☐

University entrance, NCEA level 3 ☐

Tertiary certificate or diploma (not a degree) ☐

Bachelors degree e.g. BA, BSC ☐

Postgraduate e.g. honours, masters PHD ☐

What is your current employment status?

Full time employment ☐

Part time employment ☐

Unemployed ☐

Student ☐

Retired ☐

Other ☐

Appendix E.

Outline for Participant Interviews

Interview Outline

Things to do first:

- **Info sheet**
- **Consent form**
- **Demographic form**
- **List of helplines**
- **Questions before we start**

Intro

- If you wouldn't mind I'd like to hear about a bit about you before we start, to help me to get to know you.
- What made you decide to participate in this study?
-

What do you worry about?

- Specific concerns - "are there any particular worries that you want to share?"
- Why do you think you worry about that in particular?
- Do your worries change or is it the same consistent worry?
- What does it mean to you to be healthy?

How does your worrying impact your life?

- What have been the consequences of these worries on your life?

Coping

- What do you do when you're worrying about your health?
- Healthy habits?
- In what ways have you responded to these worries?
- What have been the effects of these responses?

Treatment experiences?

Goals for the future?

Appendix F.

Braun and Clarke (2006) Analytic Procedure

Phase	Examples of procedure for each step
1. Familiarising oneself with the data	Transcribing data: Reading and re-reading, noting down initial codes
2. Generating initial codes	Coding interesting features of the data in a systematic fashion across the data-set, collating data relevant to each potential theme
3. Searching for themes	Collating codes into potential themes; gathering all data relevant to each potential theme
4. Involved reviewing the themes	Checking if the themes work in relation to the coded extracts and the entire data set, generate a thematic map
5. Defining and naming themes	Ongoing analysis to refine the specifics of each theme generating of clear names for each theme
6. Producing the report	Final opportunity for analysis selecting appropriate extracts; discussion of the analysis; relate back to research question or literature, produce report

Appendix G

Ethics Summary

- Despite this being viewed as a low risk study, procedures were put in place to manage risk should it arise.
- Consultation took place with a number of clinical psychologists prior to this study being decided as low risk.

1. In the initial stages consultation took place with the researcher and her two supervisors. Discussions were had around the most likely risk scenarios for this research and how this would be managed.
2. An ethics proposal was presented to two experienced psychologists for their feedback. Following this, the plan was adapted with their comments.
3. The ethics proposal then went through further peer review in the process of confirming the doctorate.
4. A plan was then put in place to manage the ethical concerns of this study. This included rule out criteria of high risk being specified in the initial information sheet. This was then re-iterated at the onset of interview. Participants were provided with a resource of phone numbers that they could contact should they become distressed. Should they become highly distressed, the data collection in interview would cease and one-off consultations with a clinical psychologist would be offered following containment by the researcher (a psychology trainee) and safety planning if needed.

Appendix H

Research Case Study

The current case study outlines my ongoing Doctoral research. This research seeks to explore the experience of those who self-identify as worrying 'excessively' about their health. Nine non-clinical participants have been interviewed around their experience of this phenomenon. An inductive thematic analysis was conducted to explore this data. This case study focuses on the relationships of these participants with health care professionals. The findings are organised under the theme of 'invalidation' with three subthemes of 'labelling' and 'not being heard.' The case study will then reflect on the influence of this thesis on the undertaking of the clinical internship year.

Introduction

It is not uncommon for us to worry about our health, in fact this worry is adaptive, after all, good health is intrinsic to our survival (Abramowitz & Braddock, 2008). Being mindful of our health might convince us to pay a visit to our doctor or our dentist, or to get outside for a walk. Although, is not uncommon for us to have concerns about our health, for some people this anxiety becomes overwhelming and an enduring source of distress (Abramowitz & Braddock, 2008). The research around this phenomenon is largely pathologizing, with most of the literature exploring this experience through a diagnostic lens. It can also prove confusing, with the terms health anxiety and hypochondriasis often being used interchangeably. This inconsistency appears to reflect the changing understanding of these experiences, and the reframing of the experience of 'hypochondriasis' as 'health anxiety.' It is apparent that the literature has begun to move away from the label of hypochondriasis, a label largely perceived to be pejorative, often associated with malingering(Abramowitz & Braddock, 2008). However, this confusion perhaps also speaks to an absence of understanding of this experience.

The concept of health anxiety refers to those who worry about having a serious illness/disease. Health anxiety is not a clinical diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychological Association, 2013). Rather it is conceptualised as a spectrum of symptoms embodying disproportionate fears around health and illness, running on a continuum from mild concerns to severe (Asmundson et al., 2001; Abramowitz & Braddock, 2008). Our understandings of how this phenomenon presents in the community are limited. When the full DSM-IV criteria of hypochondriasis are applied the community prevalence sits at around 0.04% (Looper & Kirmayer, 2001; Martin & Jacobi, 2006; Bleichhardt & Hiller, 2007). Exact prevalence rates in New Zealand have not yet been

identified, but it is anticipated that they sit around the same as those found in general population studies. With less restrictive criteria, it is estimated that the prevalence will be around 1%, suggesting that the diagnostic focus of this disorder excludes a proportion of people who associate with some of the concerns experienced in health anxiety (Starcevic & Noyes, 2014). Although the research has found relatively low rates of diagnosable hypochondriasis in the community, it has found that significant illness worry or hypochondriacal worry is relatively common (Noyes Jr, 2005). As such, it appears that the diagnoses may be failing to provide insight into the idiosyncrasies and nuances of this disorder (Abramowitz & Braddock, 2008). In a study by Looper and Kirmayer (2001), only 1 of their 533 participants met the full criteria for DSM-IV hypochondriasis. As such, these results indicate that people in the community meeting full diagnostic criteria as outlined by the DSM-IV are. A number of other studies have found low rates of people meeting full criteria for hypochondriasis but large numbers of people who fall within the subthreshold of these syndromes (García-Campayo, Lobo, Pérez-Escheverría, & Campos, 1998; Kirmayer & Robbins, 1991; Martin & Jacobi, 2006; Noyes Jr, 2005). This suggests that when health anxiety is explored as a continuum, with normal illness worry on one side and DSM-IV hypochondriacal worry on the other, more people identify as having health anxiety (Noyes Jr, 2005).

As discussed, most of the research in this field has been conducted on clinical populations, commonly using ICD-10 and DSM-IV criteria for screening. As such, it is important to build an evidence base for non-clinical populations, as it seems apparent that using diagnostic criteria can be too restrictive, and likely misses out a large proportion of people who excessively worry about their health. Furthermore, data suggests the increasing rates of mental distress in New Zealand, increasing from 7.6% in 2016/17 up to 8.6% in 2018 (New Zealand Mental Health Foundation, 2018). As such it is important that we work to increase our understanding of health anxiety within the New Zealand context, and how this plays out for both the people that suffer

with it and the services they engage with. Moreover, understandings of the lived experience of health anxiety will help to facilitate understandings of best treatment practice for both New Zealand and other comparable countries. Even mildly elevated health anxiety levels are associated with decreased quality of life, increased health care utilization and are a putative risk factor for more severe health anxiety (Ferguson, 2009)

The experience of worrying about one's health is still largely unstudied and recent shifts of definitions and understandings of it suggest the necessity of further research into this area. In particular, there is an absence of qualitative research in this area. Qualitative research proves crucial to gain insight into the experiences of those who experience anxiety around their health. Prior qualitative research has been largely focused on specific research questions such as use of the internet and relationships with health professionals. In order to gain more understanding of health anxiety more inductive research is needed looking into the experience of people who suffer with anxiety around their health.

Health Anxiety in Primary Care

A systematic review conducted by Creed and Barsky (2004) estimated the prevalence of hypochondriasis to be between 0.8% to 8.5% in primary care. This study used the diagnostic criteria, so it seems likely that non-clinical levels of health anxiety sit at an even higher prevalence in the population and primary care. Research also suggests that patients with medically unexplained symptoms have high rates of medical outpatient visits, but not significantly higher rates of mental health outpatient visits (Barsky et al., 2001). Therefore, patients with unexplainable medical symptoms are more often encountered in primary care than in mental health outpatient care, which often proves "taxing" and "frustrating" for the practitioners involved (Barsky et al., 2001). Furthermore, this presentation means that many cases of health anxiety will be missed in medical settings, with only the more severe cases

where there are multiple admissions and frequent tests, to be identified by professionals (Tyrer, 2013). As such, people suffering from nonclinical levels of health anxiety are unlikely to be identified in these medical settings, and therefore are likely to remain untreated.

In line with this, research has suggested the high amount of resources used by people experiencing excessive concerns about their health. Barsky et al. (2001) examined the level of resource utilization of patients with high levels of somatization and health-related anxiety through analysis of 976 patients at a primary care clinic. Their results showed that the patients in the top 14% of somatization and hypochondriacal health anxiety had a significantly higher utilization of resources than the rest of the patients in the clinic, even after accounting for sociodemographic differences and medical morbidity. It is of note that many patients presenting with hypochondriasis have comorbid mental illness, often presenting with depression and anxiety disorders. Conroy et al. (1999) investigated potential associations between health anxiety and frequency of general practitioner appointments. Their study included 200 general practice attendees who completed the Health Anxiety Questionnaire. It was of note that all of the scores for their participants scored in the lowest third of this instrument, suggesting lower levels of health anxiety. Nevertheless, the results showed that higher scores on the instrument were associated with higher numbers of self-initiated practitioner visits in the past year. Importantly, this suggests that it establishes a link between variations even within the 'normal' range of health anxiety, and increased numbers of surgery visits. These findings highlight the importance of further exploring non-clinical levels of health anxiety.

Relationships with Health Professionals

People suffering with anxiety about their health often do not find long-term reassurance from health professionals (Persing et al., 2000). Furthermore, the importance of the role of the health professional on 'legitimizing' their illness puts pressure on the physician to find an explanation for their symptoms and the appropriate treatment (Barsky et al., 1991). As such, this need for reassurance is often combined with a level of hostility which can prove challenging to the relationship (Barsky et al., 1991). Therefore, increased understanding of the patient's perspective of hypochondriasis and the practitioner's perspective may help to mediate some of the frustrations that often become apparent in these relationships. Persing et al. (2000) investigated the experience of hypochondriasis in the medical setting from the patient's perspective. They interviewed 20 patients with DSM-III-R hypochondriasis and 26 patients without, using a semi-structured interview. Their results suggested that those with hypochondriasis demonstrated more negative attitudes towards healthcare professionals than those without the diagnosis. The participants with hypochondriasis expressed feeling that their medical care had not greatly benefitted them and that many of the physicians they crossed paths with seemed uncaring or indifferent to their experience (Persing et al., 2000).

An earlier study by Barsky et al. (1991) also examined the views that hypochondriacal patients have of their physicians but also the views that physicians have of these patients. Like Persing et al. (2000), Barsky et al. (1991) also interviewed participants with DSM-II-R hypochondriasis, and then comparison subjects. Barsky et al. (1991) found that hypochondriacal patients were more dissatisfied with their clinicians than comparison patients. In turn, the physicians rated hypochondriacal patients as more frustrating to care for, more help-rejecting and more demanding than comparison subjects. These papers provide a valuable

insight into what can prove to be a frustrating dynamic. Research suggests that physicians often find hypochondriacal patients hard to deal with, and hypochondriacal patients do not feel heard by their clinicians. As such, the relationship between healthcare provide and hypochondriacal patient often appears to be a challenging dynamic, despite the often critical aspect of this relationship in the hypochondriacal experience.

Method

This doctoral research hopes to provide some insight in to the lived experience of people who worry to 'excess' about their health. In this case, 'excess' was deemed to be when their worrying impacted on their functioning. As a result of the desire to build a rich narrative of the experience of health worry, this was an inductive study, inquiring about their worries, what they considered contributed to these, the impact of these worries on them and how they cope. This emphasis on personal experience was chosen as a result of the changing understandings of what it means to be health anxious, as shown in the changing diagnostic criteria as well as the high levels of missed diagnoses, suggesting uncertainty in our understanding of this experience. This inductive analysis was intended to help to expand theory surrounding thoughts and behaviours in this area, as well as to see how these fit with the current theoretical understandings. An inductive form of thematic analysis was therefore chosen as the method that best fit the intentions of this study. The inductive approach of this analysis means that the data strongly forms the findings of this study, and the themes may not fit what exactly was asked of the participant in the initial questioning (Braun & Clarke, 2002).

The criteria for inclusion in the study was that participants be aged 18 years and above, who

self-identify as having excessive concerns about their health. Participants were not required to have a diagnosis of illness anxiety disorder or somatic symptom disorder as outlined in the DSM-5 and participants were not screened for this. Participants were recruited from the community through a number of methods, these included flyers on community notice boards, flyers on university noticeboards, recruitment through Doctor's surgeries and posts on Facebook groups for anxiety support as well as local community Facebook groups. 'Snowballing' was also used through posts on Facebook, which were shared by friends and one doctor's surgery who shared it on their public Facebook page. The flyer included a small amount of information about the study, as well as a contact email set up specifically for the study which potential participants could contact for further information.

Participants were excluded if they had an unstable or life-threatening medical or neurological disorder, had a current or lifetime diagnostic of psychotic symptoms or a high risk of suicide. Participants were also excluded if they were too medically unwell or distressed to attend the interview, as there were concerns of further aggravating any medical or distressing symptoms through the content or experience of the interview. The exclusion criteria of having an unstable or life-threatening medical or neurological disorder proved challenging in a couple of cases, as some participants did present with chronic medical issues, but through consultation with them these illnesses were deemed to be stable and non-life threatening.

Semi-structured interviews were used to allow for flexibility in participant experience, to allow them to share their experiences outside of strict interview protocol, in line with the inductive methodology of this study. The length of interviews ranged from around 50 minutes to 90 minutes. The questions focused on all understanding how their health concerns have impact their functioning, whether this be at home or at work or in their relationships. The questions were based around a loose interview guideline established at the beginning of recruitment

aimed to understand how these concerns presented, how they experienced them, how these impact their functioning and how they coped. Enquiries included any particular health concerns they had, what methods they used to cope with these concerns, what they perceived 'good health' to be and how they felt they had been impacted by these concerns whether this be in family situations, relationships or at work. This interview guideline was altered after the first three interviews to incorporate some of the information that had come up in the interviews so far. Following the interview, the interviews were transcribed by the researcher.

Findings

Invalidation

Throughout their interactions with health care providers, the participants repeatedly reported feeling invalidated by health care professionals through a number of mechanisms. This theme will be broken down into the subthemes of 'labelling,' and 'not being heard.'

Labelling

Two of the participants reported feeling 'labelled' by medical professionals as a result of their previous mental health concerns. These participants felt that their experience of physical symptoms were not taken into account because of health concerns they had experienced in the past. This shared narrative is summed up by a participant in the quote below.

> P2=…*if you have even mild anxiety prior to any major or um…health problem…you get labelled…and so you get lumped into the mental health of you've got anxiety*

Interestingly, this participant made sure to emphasise the 'mildness' of her anxiety prior to this experience, perhaps as a tool to prevent the researcher from categorising her experience as anxiety, as many doctors have before.

Participant 1 also discussed the experience of 'labelling.'

> P1 = *…so I remember thinking back then, somethings not right I know somethings not right, I know I'm a new mum, I was a very new mum, I was very tired and very anxious, I had postnatal depression which was already I felt like a label that was stuck, I was fine with the diagnosis but I felt like because of that that all the doctors and…threw it off as PND*

It appears that this participant's concerns about her child were overlooked by medical professionals, who attributed these to her post-natal depression (PND), causing her to likely feel that her concerns were devalued. Her use of dismissive language such as "threw it off" suggesting that her concerns were labelled as PND related, and therefore perhaps seen as unimportant or of lesser value. Later it eventuated that in fact her child was ill, and therefore her concerns were validated. One can imagine the sense of unease that you could experience from having your concerns proved right even though medical professionals doubted you. Perhaps it left her with a sense of not knowing who to trust, whether to always trust her own judgment because she was right last night and they were wrong? Perhaps it created a sense of unease around the ability of medical professionals to pick up on illness? In any case, she attributes a significant amount of her health anxiety to the experience of seeking help for her child who she believed was ill, not being heard or validated by professionals.

Participant 2 also used language to suggest that her experiences were perceived to be anxiety

> P2= *So then going back to the doctor, going back, trying, I was literally screaming out for help and then they were all going 'its all just anxiety, its all just anxiety' that's just what they kept putting it down to and that point yep it was but I didn't register the whole pattern of how it happened until much later*

It is hard to tell whether this was the exact language used by the physician or the participant, but nevertheless the phrase "all just anxiety" is significant. Similarly to the previous use of "threw it off," the word "just" works to minimise 'anxiety' potentially placing it as a below a physical ailment. From the extract above, one can get a sense of her feelings of frustration with medical professionals, as she notes "screaming out for help" and needing to keep "going back, trying." This narrative creates a sense of her desperation to find a physical cause for these symptoms. It seems as though this behaviour could be interpreted as 'reassurance seeking' or 'doctor shopping' where she repeatedly kept going to a medical professional for a physical diagnosis. Although it seems feasible that these symptoms may have been anxiety-related, her doctor failed to explain how this might be playing out for her and it was not explained until months later when she was referred to her psychiatrist. Perhaps if this pattern had been explained to her earlier on her need to keep looking for cause would have been lessened. This experience suggests some kind of mind/body distinction portrayed by medical professionals towards her. She was told that everything was anxiety, but the idea that her physical symptoms could in fact be anxiety was not explained.

> *P2 = Um…so by the time January came around, I was struggling over the Christmas break, my Doctor was on holiday, there was no point going back to hospital, I felt very much alone and that I had no one to go to. Where do you go when you're too sick to be at home but hospital won't take you? Um…and so 3rd of January, because of all that and because I didn't know where to go, I had a nervous breakdown*

This participant further details her distress at repeatedly being told what she was experiencing was anxiety. Her description of being "alone" and feeling that she had "no one to go to," suggesting feelings of abandonment by the medical system. This experience falls in line with the research regarding the relationship between people with health anxiety and medical

professionals. The physician's initial role and aim is to find the physical cause of her ailments, and then when failing to find this, physicians often shift to containing excessive help-seeking behaviours (Looper & Kirmayer, 2002). Sometimes patients are given a psychiatric referral at this point, when it becomes clear to the doctor that this problem does not fit within their disease/diagnostic model (Hart & Björgvinsson, 2010). This can often be distressing to patients, as they feel that their physical symptoms have been invalidated and that the experience they are having is 'all in their head' (Hart & Björgvinsson, 2010). As such we can see that some patients who do not fit within the criteria of the diagnostics may get lost within the system.

Not Being Heard

A common thread running through narratives is that of 'not being heard.' Many of the participants experienced frustrations with their concerns being dismissed or ignored.

> *P8 = …when I went home though, but because of having that five weeks of not being heard that's when the anxiety started to build up, so when I got home it morphed into anxiety*

This participant suggests that her anxiety was not present before experiencing these physical sensations, but rather evolved as a result of "not being heard" by medical professionals. She believes that the experience of not being listened to evolved into anxiety symptoms, which she reported were not present initially. As such, it could be perceived that this participant views the feeling of not being heard as the trigger for her ongoing anxiety. Research suggests that frequent emergency room attenders are often put on a time-out by physicians, where the person has to wait a long amount of time to be seen in a bid to stop them repeatedly returning(Asmundson et al., 2001) However, such a dismissive approach can often make these patients feel like they are not getting the care they need. In response to this, research suggests

that a person's belief that they have an undiagnosed condition can be strengthened (Asmundson et al., 2001).

Participant 8 discussed her repeated visits to the A and E as a result of the physical sensations she was experiencing, which she believed were a result of the anti-depressants that she had been prescribed. She described repeatedly being told that she was "fine" and sent home. On one occasion she called an ambulance because of repeated physical sensations but as her stats were fine the ambulance refused to take her to hospital. As a result of this repeated sense of 'not being heard' participant 8 called an ambulance and feigned a stroke as a means to get seen in hospital.

> *INT = So how did it feel when you felt these physical sensations, and they were telling you that it wasn't…*
>
> *P8 = Oh well that's when the anxiety just got worse and worse, because I wasn't being heard I was told that it was all anxiety related, when at that point I didn't have the anxiety, I was just feeling these physical symptoms. So the fourth time, which was now five weeks later from when it started I was at work and my right side went weak, now I'm not silly and I knew that they'd have to take me because I'd be a potential stroke. So I played on it, it was the only way I knew I was going to get into hospital, so I had called an ambulance again, the right side of me did go weak but it wasn't as weak as what I made out it was, so they took me straight to hospital.*

As detailed above participant 8 felt that her physical symptoms had been so invalidated by health professionals, that she ended up exaggerating her symptoms to suggest she was having a stroke. It appears that in this participant's experience, her anxiety symptoms came after the

experience of physical sensations, and unlike participant 2, does not believe that at this time her physical experiences could be attributable to her anxiety. As such, it appears that this participant's experience was almost a self-fulfilling prophecy, as she had to feign illness as a means to feel seek help.

> *P5 = Which is what I don't like about like the medical…someone in authority did something to me, didn't listen to me and did something to me and it had a profound impact on my life*

This extract brings up a sense of invalidation by medical professionals, where she felt she ignored by health professionals and then harmed by them. This experience speaks to the power dynamic experienced by patients and doctors, as she relays the imbalance of power and the "profound impact" that the consequences of this have had on her life.

Participant (2) discussed the concerns she feels when her GP cannot provide her with a viable reason for her physical symptoms

> *P2=…especially with my GP if he can't find the reason why I'm always going to think in the back of my head, like what if this develops into a huge problem in the future. So one of the things I searched up is that I might have appendicitis or a stomach ulcer and stomach ulcer's need to be removed like what if it's left too late and I develop stomach cancer, it's just all the build up*
>
> *INT = So it feels like it's a rolling ball, and it's getting worse and worse and worse?*
>
> *P2 = It's like a snowball, and it picks up the snow and it gets bigger*

The realness of her experience of physical sensations and not having the validation of a medical diagnosis for these problems proved concerning for this participant. She does not appear to find the fact that her GP has found no physical problem reassuring. Instead her analogy of the

"snowball" suggests the increase that this lack of diagnosis has on her levels of anxiety, as the snowball starts to roll, picking up more and more anxious thoughts. Research suggest that when people with hypochondriasis are not given a 'valid' explanation for their problems by their physician, they often blame the physician's lack of thoroughness or knowledge (Persing et al., 2000). In line with this, this participant discussed her views on her GP's knowledge.

> *P2 = Yeah I've asked multiple times 'oh why is this happening?' and then he'll be like 'oh maybe from this, maybe from that' but it's never like confident, it sounds like just rambling um…I think that's my main issue*
>
> *INT = you'd like something concrete? And this is what's going on?*
>
> *P2 = Mmm…yeah, because if it's been happening to me for years, you kind of start to be like why, and especially doing nursing it gets me even more aggravated because if I can come up with so many diagnoses for just a couple of symptoms, why can't he just come up with at least one logical reasoning behind why I'm always sick with this stomach thing*

This participant relays the frustration that can often emerge in interactions with doctors and people with health anxiety. It appears critical to that doctors provide concrete reasoning for their experience of symptoms, even though conceivably these symptoms may not be attributable to any physical ailment. These comments also speak to the assumption that the doctor holds knowledge which has power over their experience of these symptoms, as well as power to legitimise their experience.

References

Abramotwitz, J., Olatunji, B.O. & Deacon, B.J. (2007). Health anxiety, hypochondriasis and the anxiety disorders. *Behavior Therapy 38,* 86-94.

Abramowitz J.S, Braddock A.E. (2008). Psychological Treatment of Health Anxiety and Hypochondriasis: A Biopsychosocial Approach. Cambridge, MA: Hogrefe & Huber

Asmundson, G. J. G., Taylor, S., & Cox, B. J. (2001). Health Anxiety: Clinical and Research Perspectives on Hypochondriasis and Related Conditions. Wiley.

Barsky, A. J. (2001). The patient with hypochondriasis. New England Journal of Medicine, 345, 1395-1399.

Barsky, A. J., Wyshak, G., Latham, K. S., & Klerman, G. L. (1991). Hypochondriacal patients, their physicians, and their medical care. Journal of General Internal Medicine, 6(5), 413–419. https://doi.org/10.1007/BF02598162

Bleichhardt G, Weck F. 2007. Kognitive Verhaltenstherapie bei Hypochondrie und Krankheitsangst. Heidelberg: Springer

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3, 77-101.

Conroy, R. M., Smyth, O., Siriwardena, R., & Fernandes, P. (1999). Health anxiety and characteristics of self- initiated general practitioner consultations. Journal of psychosomatic research, 46(1), 45-50.

Creed, F., & Barsky, A. (2004). A systematic review of the epidemiology of somatizations disorder and hypochondriasis. Journal of Psychosomatic Research, 56(4), 391-408.

Ferguson, E. (2009). A taxometric analysis of health anxiety. Psychological Medicine 39(2), 277-285.

García-Campayo, J., Lobo, A., Pérez-Escheverría, M. J., & Campos, R. (1998). Three forms of somatization presenting in primary care settings in Spain. Journal of Nervous and Mental Disease, 186(9), 554–560. https://doi.org/10.1097/00005053-199809000-00006

Hart, J., & Björgvinsson, T. (2010). Health anxiety and hypochondriasis: Description and treatment issues highlighted through a case illustration. Bulletin of the Menninger Clinic, 74(2), 122–140. https://doi.org/10.1521/bumc.2010.74.2.122

Kirmayer, L. J., & Robbins, J. M. (1991). Three forms of somatization in primary care: prevalence, co-occurrence, and sociodemographic characteristics. The Journal of Nervous and Mental Disease, 179(11), 647–655.

Looper, K. J., & Kirmayer, L. J. (2002). Behavioral medicine approaches to somatoform disorders. Journal of Consulting and Clinical Psychology, 70(3), 810–827. https://doi.org/10.1037/0022-006X.70.3.810

Martin, A., & Jacobi, F. (2006). Features of Hypochondriasis and Illness Worry in the General Population in Germany: Psychosomatic Medicine, 68(5), 770–777. https://doi.org/10.1097/01.psy.0000238213.04984.b0

Noyes Jr, R. (2005). Hypochondrais: A review. In M. Maj, H. S. Akiskal, J. Mezzich, & A. Okasha (Eds.), Somatoform Disorders (pp. 129–159). John Wiley & Sons.

Persing, J. S., Stuart, S. P., Noyes, R., & Happel, R. L. (2000). Hypochondriasis: The Patient's Perspective. The International Journal of Psychiatry in Medicine, 30(4), 329–342. https://doi.org/10.2190/KMXW-T53N-BTDW-GTGH

Salkovskis, P. M., & Warwick, H. (2001). Making sense of hypochondriasis: a cognitive theory of health anxiety. Health Anxiety: Clinical and Research Perspectives on Hypochondriasis and Related Conditions, 46–64.

Starcevic, V., & Noyes, R. (2014). Hypochondriasis and Health Anxiety: A Guide for Clinicians. New York, USA: Oxford University Press.

Tyrer P, Cooper S, Crawford M, et al: Prevalence of health anxiety problems in medical clinics. J Psychosom Res 2011; 71:392–394